UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1032-13
Program	Prior Authorization/Notification
Medications	Firazyr® (icatibant)*, icatibant, Sajazir™ (icatibant)*
P&T Approval Date	11/2011, 11/2012, 11/2013, 8/2014, 8/2015, 7/2016, 7/2017, 7/2018, 7/2019, 7/2020, 7/2021, 7/2022, 4/2023, 2/2024, 2/2025
Effective Date	5/1/2025

1. Background:

Firazyr (icatibant)* is a bradykinin B2 receptor antagonist indicated for treatment of acute attacks of hereditary angioedema (HAE) in adults 18 years of age and older. Sajazir (icatibant)* injection is a bradykinin B2 receptor antagonist indicated for treatment of acute attacks of HAE in adults 18 years of age and older.

2. Coverage Criteria[a]:

A. Firazyr*, icatibant, or **Sajazir*** will be approved based on **all** of the following criteria:

1. Diagnosis of hereditary angioedema (HAE)

-AND-

2. Prescribed for the treatment of acute HAE attacks

-AND-

3. Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Berinert, Kalbitor, or Ruconest)

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

* Firazyr (brand) and Sajazir are typically excluded from coverage. Coverage reviews may be in place if required by law or the benefit plan.

3. Additional Clinical Programs:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Firazyr [package insert]. Lexington, MA: Takeda Pharmaceuticals America, Inc.; January 2024.
2. Sajazir [package insert]. Cambridge, CB3 0FA, United Kingdom: Cycle Pharmaceuticals Ltd; February 2024.

Program	Prior Authorization/Notification - Firazyr (icatibant), Sajazir (icatibant)
Change Control	
11/2013	Annual review. Removed requirement for Type I or II HAE. Changed authorization duration from 12 months to 60 months.
8/2014	Annual review. Added an additional criterion that does not allow combination use with other HAE acute treatments. Decreased authorization from 60 months to 12 months. Updated Background and References.
8/2015	Annual review. No change.
7/2016	Annual review with no changes to the clinical criteria. Updated background and references.
7/2017	Annual review. No changes to program.
7/2018	Annual review. No changes to program.
7/2019	Annual review. No changes to program.
7/2020	Annual review. No changes to coverage criteria.
7/2021	Annual review. No changes to coverage criteria. Reference updated.
7/2022	Annual review with no changes to coverage criteria. Added state mandate footnote. Updated reference.
4/2023	Added Sajazir, updated background, and updated references.
2/2024	Added coverage exclusion statement for brand Firazyr and Sajazir. Revised wording of criteria without changes to clinical intent.
2/2025	Annual review with no changes to coverage criteria. Updated reference.