PRIOR AUTHORIZATION POLICY

POLICY: Hereditary Angioedema – Icatibant Prior Authorization Policy
- Firazyr® (icatibant subcutaneous injection – Takeda, generic)
- Sajazir™ (icatibant subcutaneous injection – Cycle)

REVIEW DATE: 10/09/2024

OVERVIEW

Icatibant is a synthetic decapeptide that is indicated for the **treatment of acute hereditary angioedema (HAE) attacks** in adults ≥ 18 years of age.[1]

Guidelines

According to US HAE Association Medical Advisory Board Guidelines (2020), when HAE is suspected based on clinical presentation, appropriate testing includes measurement of the serum C4 level, C1 esterase inhibitor (C1-INH) antigenic level, and C1-INH functional level.[2] Low C4 plus low C1-INH antigenic or functional level is consistent with a diagnosis of HAE types I/II. The goal of acute therapy is to minimize morbidity and prevent mortality from an ongoing HAE attack. Patients must have ready access to effective on-demand medication to administer at the onset of an HAE attack. All HAE attacks are eligible for treatment, irrespective of the location of swelling or severity of the attack. First-line treatments include plasma-derived C1-INH, Ruconest® (C1-INH [recombinant] intravenous [IV] infusion), Kalbitor® (ecallantide subcutaneous injection), and icatibant.

In guidelines from the World Allergy Organization/European Academy of Allergy and Clinical Immunology (2021), it is recommended that all attacks be treated with either IV C1-INH, Kalbitor, or icatibant (evidence level A for all).[3] Regarding IV C1-INH, it is noted that Berinert® (C1 esterase inhibitor [human] IV infusion) and Cinryze® (C1 esterase inhibitor [human] IV infusion) are both plasma-derived products available for this use, although indications vary globally. It is essential that patients have on-demand medication to treat all attacks; thus, the guidelines recommend that patients have and carry medication for treatment of at least two attacks.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of icatibant. Because of the specialized skills required for evaluation and diagnosis of patients treated with icatibant, approval requires icatibant to be prescribed by or in consultation with a physician who specializes in the condition being treated. All approvals are provided for the duration noted below. A patient who has previously met initial therapy criteria for icatibant for the requested indication under the Coverage Review Department and is currently receiving the requested therapy is only required to meet the continuation therapy criteria (i.e., patient who has treated previous HAE attacks with icatibant). If past criteria have not been met under the Coverage Review Department and the patient has treated previous HAE attacks with icatibant, initial therapy criteria must be met.

Documentation: Documentation will be required where noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, laboratory records, and prescription claims records.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of icatibant is recommended in those who meet the following criteria:

FDA-Approved Indication

1. **Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency – Treatment of Acute Attacks.** Approve for 1 year if the patient meets ONE of the following (A or B):
   - **A)** Initial therapy. Approve if the patient meets BOTH of the following (i and ii):
     - **i.** Patient has HAE type I or type II as confirmed by the following diagnostic criteria (a and b):
       Note: A diagnosis of HAE with normal C1-INH (also known as HAE type III) does NOT satisfy this requirement.
       - **a)** Patient has low levels of functional C1-INH protein (< 50% of normal) **at baseline**, as defined by the laboratory reference values **[documentation required]**; AND
       - **b)** Patient has lower than normal serum C4 levels **at baseline**, as defined by the laboratory reference values **[documentation required]**; AND
     - **ii.** The medication is prescribed by or in consultation with an allergist/immunologist or a physician who specializes in the treatment of HAE or related disorders.
   - **B)** Patient who has treated previous HAE attacks with icatibant. Approve if the patient meets ALL of the following (i, ii, and iii):
     Note: If the patient is currently receiving the requested therapy but has not previously received approval of icatibant for this indication through the Coverage Review Department, review under criteria for Initial Therapy.
     - **i.** Patient has a diagnosis of HAE type I or type II **[documentation required]**; AND
       Note: A diagnosis of HAE with normal C1-INH (also known as HAE type III) does NOT satisfy this requirement.
     - **ii.** According to the prescriber, the patient has had a favorable clinical response with icatibant treatment; AND
       Note: Examples of a favorable clinical response include decrease in the duration of HAE attacks, quick onset of symptom relief, complete resolution of symptoms, or decrease in HAE acute attack frequency or severity.
     - **iii.** The medication is prescribed by or in consultation with an allergist/immunologist or a physician who specializes in the treatment of HAE or related disorders.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of icatibant is not recommended in the following circumstances:

1. **Hereditary Angioedema (HAE) Prophylaxis**. Data are not available and icatibant is not indicated for prophylaxis of HAE attacks.

2. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Firazyr® subcutaneous injection [prescribing information]. Lexington, MA: Takeda; October 2021.
2. Busse PJ, Christiansen SC, Riedl MA, et al. US HAEA Medical Advisory Board 2020 guidelines for the management of hereditary angioedema. *J Allergy Clin Immunol Pract*. 2021;9(1):132-150.e3.
3. Maurer M, Magerl M, Betschel S, et al. The international WAO/EAACI guideline for the management of hereditary angioedema: the 2021 revision and update. *Allergy*. 2022;77(7):1961-1990.