



UnitedHealthcare Pharmacy  
Clinical Pharmacy Programs

Program Number	2024 P 1032-12
Program	Prior Authorization/Notification
Medications	Firazyr <sup>®</sup> (icatibant)*, icatibant, Sajazir <sup>™</sup> (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
Effective Date	5/1/2024

**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.<sup>1</sup> 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.<sup>2</sup>

**2. Coverage Criteria<sup>a</sup>:**

**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.**

<sup>a</sup> 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.; October 2021.
2. Sajazir [package insert]. Cambridge, CB3 0FA, United Kingdom: Cycle Pharmaceuticals Ltd; May 2022.

Program	Prior Authorization/Notification - Firazyr (icatibant), Sajazir (icatibant)
<b>Change Control</b>	
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.