Mass General Brigham
Health Plan

Firazyr (icatibant)
Sajazir (icatibant)
Effective 01/01/2024

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☒ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☒ Medical Benefit		
Specialty Limitations	These medications have been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	**Medical and Specialty Medications** All Plans | Phone: 877-519-1908 | Fax: 855-540-3693		
	Non-Specialty Medications All Plans | Phone: 800-711-4555 | Fax: 844-403-1029		
Exceptions	N/A		

Overview

FDA-Approved Indication

Treatment of acute attacks of hereditary angioedema (HAE) in adults 18 years of age and older.

All other indications are considered experimental/investigational and not medically necessary.

Coverage Guidelines

Authorization may be granted for members new to the plan who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance programs.

OR

Authorization may be granted when the following criteria is met:

1. The requested medication will not be used in combination with any other medication used for the treatment of acute HAE attacks.
2. The requested medication must be prescribed by or in consultation with a prescriber who specializes in the management of HAE.
3. Member meets ONE of the following criteria:
    a. Member has C1 inhibitor deficiency or dysfunction as confirmed by laboratory testing and meets ONE of the following criteria:
        i. C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test, or
        ii. Normal C1-INH antigenic level and a low C1-INH functional level (functional C1-INH less than 50% or C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test).
    b. Member has normal C1 inhibitor as confirmed by laboratory testing and meets one of the following criteria:

i. Member has an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation as confirmed by genetic testing, or
ii. Member has a documented family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy (i.e., cetirizine at 40 mg per day or the equivalent) for at least one month.

Continuation of Therapy

Reauthorization may be granted for continuation of therapy when all of the following criteria are met:

1. Member meets the criteria for initial approval.
2. Submission of chart notes demonstrated that member has experienced a reduction in severity and/or duration of acute attacks.
3. Prophylaxis should be considered based on the attack frequency, attack severity, comorbid conditions, and member's quality of life.

Limitations

1. Initial approvals and reauthorizations will be granted for 6 months.

References

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Review History

12/13/2023: Reviewed at Dec P&T, switched from SGM to Custom. Effective 1/1/2024