



## Firazyr® (icatibant) (Subcutaneous)

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### I. Length of Authorization

Coverage will be provided for 12 weeks and is eligible for renewal (unless otherwise specified).

The cumulative amount of medication(s) the patient has on-hand, indicated for the acute treatment of HAE, will be taken into account when authorizing. The authorization will provide a sufficient quantity in order for the patient to have a cumulative amount of HAE medication(s) on-hand in order to treat up to 4 acute attacks per 4 weeks for the duration of the authorization (unless otherwise specified).

### II. Dosing Limits

#### A. Quantity Limit (max daily dose) [NDC Unit]:

- Firazyr 30 mg prefilled syringes for injection: 12 injections per 28 days

#### B. Max Units (per dose and over time) [HCPCS Unit]:

- 360 billable units per 28 days

### III. Initial Approval Criteria <sup>1</sup>

Coverage is provided in the following conditions:

- Patient is at least 18 years of age; **AND**

#### Universal Criteria <sup>1,13,18</sup>

- Must be prescribed by, or in consultation with, a specialist in: allergy, immunology, hematology, pulmonology, or medical genetics; **AND**
- Confirmation the patient is avoiding the following possible triggers for HAE attacks:
  - Estrogen-containing oral contraceptive agents **AND** hormone replacement therapy; **AND**
  - Antihypertensive agents containing ACE inhibitors; **AND**
  - Dipeptidyl peptidase IV (DPP-IV) inhibitors (e.g., sitagliptin); **AND**
  - Neprilysin inhibitors (e.g., sacubitril); **AND**

## Treatment of acute attacks of Hereditary Angioedema (HAE) † $\Phi$ 1,13,18,19

- Patient has a history of moderate to severe cutaneous attacks (without concomitant hives) OR abdominal attacks OR mild to severe airway swelling attacks of HAE (i.e. debilitating cutaneous/gastrointestinal symptoms OR laryngeal/pharyngeal/tongue swelling); **AND**
- Patient has one of the following clinical presentations consistent with a HAE subtype $\S$ , which must be confirmed by repeat blood testing (treatment for acute attack should not be delayed for confirmatory testing):

<b>HAE I (C1-Inhibitor deficiency) <math>\S</math> 13,18,19</b>
<ul style="list-style-type: none"><li>• Low C1 inhibitor (C1-INH) antigenic level (C1-INH antigenic level below the lower limit of normal as defined by the laboratory performing the test); <b>AND</b></li><li>• Low C4 level (C4 below the lower limit of normal as defined by the laboratory performing the test); <b>AND</b></li><li>• Low C1-INH functional level (C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test); <b>AND</b><ul style="list-style-type: none"><li>○ Patient has a family history of HAE; <b>OR</b></li><li>○ Acquired angioedema has been ruled out (i.e., patient onset of symptoms occur prior to 30 years old, normal C1q levels, patient does not have underlying disease such as lymphoma or benign monoclonal gammopathy [MGUS], etc.)</li></ul></li></ul>
<b>HAE II (C1-Inhibitor dysfunction) <math>\S</math> 18</b>
<ul style="list-style-type: none"><li>• Normal to elevated C1-INH antigenic level; <b>AND</b></li><li>• Low C4 level (C4 below the lower limit of normal as defined by the laboratory performing the test); <b>AND</b></li><li>• Low C1-INH functional level (C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test)</li></ul>
<b>HAE with normal C1INH (formerly known as HAE III) <math>\S</math> 18,19</b>
<ul style="list-style-type: none"><li>• Normal C1-INH antigenic level; <b>AND</b></li><li>• Normal C4 level; <b>AND</b></li><li>• Normal C1-INH functional level; <b>AND</b></li><li>• Repeat blood testing <u>during an attack</u> has confirmed the patient does not have abnormal lab values indicative of HAE I or HAE II; <b>AND</b></li><li>• Either of the following:<ul style="list-style-type: none"><li>○ Patient has a known HAE-causing mutation (e.g., mutation of coagulation factor XII gene [F12 mutation], mutation in the angiotensin-converting enzyme 1 gene, mutation in the plasminogen gene, etc.); <b>OR</b></li><li>○ Patient has a family history of HAE and documented evidence of lack of efficacy of chronic high-dose antihistamine therapy (e.g. <i>cetirizine standard dosing at up to four times daily or an alternative equivalent, given for at least one month or an interval long enough to expect three or more angioedema attacks</i>) <u>AND</u> corticosteroids with or without omalizumab</li></ul></li></ul>

† FDA Approved Indication(s);  $\Phi$  Orphan Drug

## IV. Renewal Criteria <sup>1</sup>

Coverage can be renewed based upon the following criteria:

- Patient continues to meet the universal and other indication-specific relevant criteria identified in section III; **AND**

- Significant improvement in severity and duration of attacks have been achieved and sustained; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include the following: severe injection site reactions, laryngeal HAE attacks, etc.; **AND**
- The cumulative amount of medication(s) the patient has on-hand, indicated for the acute treatment of HAE, will be taken into account when authorizing. The authorization will provide a sufficient quantity in order for the patient to have a cumulative amount of HAE medication(s) on-hand in order to treat up to 4 acute attacks per 4 weeks for the duration of the authorization (unless otherwise specified).

## V. Dosage/Administration <sup>1</sup>

Indication	Dose
Acute Hereditary Angioedema (HAE) attacks	30 mg injected subcutaneously in the abdominal area. May be repeated every 6 hours up to a total of 3 doses (90 mg) in 24 hours. <b>**Note:</b> Patients may self-administer Firazyr after being instructed by their healthcare provider.

## VI. Billing Code/Availability Information

### HCPCS Code:

- J1744 – Injection, icatibant, 1 mg; 1 billable unit = 1 mg

### NDC:

- Firazyr 30 mg single-use prefilled syringe (carton of 1 or 3)\*: 54092-0702-xx  
*\*Generics available from numerous manufacturers*

## VII. References

1. Firazyr [package insert]. Lexington, MA; Shire Orphan Therapies, Inc; August 2020. Accessed August 2021.
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## Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
D84.1	Defects in the complement system

## Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) may exist and compliance with these policies is required where applicable. They can be found at: <https://www.cms.gov/medicare-coverage-database/new-search/search.aspx>. Additional indications may be covered at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD/LCA): N/A

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	Applicable State/US Territory	Contractor
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA, LLC
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA, LLC
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC