Alaska Medicaid

Firazyr® (icatibant)

Available single-use, prefilled syringe 30mg/3mL

INDICATIONS and Usage:

"Firazyr® is a bradykinin B2 receptor antagonist indicated for treatment of acute attacks of hereditary angioedema (HAE) in adults 18 years of age and older."[1]

Criteria for Approval:

The prescriber must submit a letter of medical necessity along with all necessary documentation substantiating all of the criteria below.

1. The patient has a documented diagnosis of hereditary angioedema (HAE) by an immunologist; and
2. The recipient is on a prophylactic therapy (such as 17-α – alkylated androgens or anti-fibrinolytic agents) unless contraindicated or response failure.

Length of Authorization:

Firazyr: Coverage may be approved for date of service.

Dispensing Limit:

Firazyr: The dispensing limit is 3 units. Refills require documentation of Emergency Room or Hospital intervention.

References:

[1] Firazyr® package insert is available at: < http://pi.shirecontent.com/PI/PDFs/Firazyr_USA_ENG.pdf > Accessed 3/2/12