

**CRITERIA FOR PRIOR AUTHORIZATION**

Firazyr® (icatibant)

**PROVIDER GROUP** Pharmacy  
Professional

**MANUAL GUIDELINES** The following drug requires prior authorization:  
Icatibant (Firazyr)

**CRITERIA FOR PRIOR AUTHORIZATION FOR ICATIBANT:** (must meet all of the following)

- Patient must have a diagnosis of Hereditary Angioedema (HAE), with provider submitting documentation that diagnostic testing was completed
- Must be used for the treatment of an acute attack of HAE
- Patient must be 18 years of age or older
- Dose must not exceed 90 mg (3 doses) per 24 hours
- Must be initially administered by a health care professional in an outpatient or home health setting with subsequent administration by only specific persons trained who have demonstrated competence

**LENGTH OF APPROVAL:** 12 months