Drug Name: Icatibant (Firazyr®)
Effective Date: 12/12/2018
Last Revision Date: 6/2019, 5/2020
Date: 6/2019

Drug Name:	Icatibant (Firazyr®) Subcutaneous injection
Prescriber Restrictions:	Must be prescribed by, or in consultation with, a specialist in: allergy, immunology, hematology, pulmonology, or medical genetics
Age Restrictions:	18 years of age or older
Exclusion Criteria:	Patient cannot have acquired angioedema or concurrently taking an angiotensin converting enzyme (ACE) inhibitor.
Required Medical Information:	• Patient has documented diagnosis of type 1 or type II hereditary angioedema(HAE) • Diagnosis is confirmed by laboratory testing o Low C4 level (<14mg/dL) and reduced C1 esterase inhibitor level (<19.9 mg/dL) OR o Reduced C1 esterase inhibitor function (<72%) • Patient has a history of moderate to severe cutaneous or abdominal attacks OR mild to severe airway swelling attacks of HAE (i.e. debilitating cutaneous/gastrointestinal symptoms OR laryngeal/pharyngeal/tongue swelling) • Patient has a history of at least one severe attack within the past 6 months • The cumulative amount of medications the patient has on hand, indicated for the acute treatment of HAE, will not exceed maximum recommended dose of 30mg every 6 hours, for a maximum of 3 doses in 24 hours.
Continuation of therapy criteria:	• Patient is tolerating therapy and meets all initial criteria • Patent shows significant improvement in severity and duration of attacks have been achieved and sustained • The cumulative amount of medications the patient has on hand, indicted for the acute treatment of HAE, will not exceed maximum recommended dose of 30mg every 6 hours, for a maximum of 3 doses in 24 hours.
Quantity Limit	9 ml per 23 days
Coverage Duration:	6 months