Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Firazyr® (icatibant)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New Request ☐ Previously approved, request for additional doses

Drug product: ☐ Firazyr 30 mg/3 mL

Date of last dose (if applicable): _____

Ave. frequency of dosing: _____

# of syringes currently on hand: _____

# of syringes requested: _____

Drug cost information

The wholesale acquisition cost for one syringe is $9,724. The annual cost of treatment with this drug will vary depending on the patient's circumstances.

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Diagnosis of hereditary angioedema (HAE) Type I or Type II
    a. Requires submission of two sets of C4, C1-INH protein, and C1-INH function lab results confirming diagnosis.
2. Greater than 18 years old
3. Patient is not on an ACE inhibitor
4. Patient does not have a history of ischemic heart disease
5. Firazyr is being used only for the treatment of acute attacks
6. Must be refractory to at least one optimized prophylactic treatment including an androgen and/or antifibrinolytic (e.g. danazol 600 mg total daily dose)

- Firazyr is limited to a total of three syringes on hand. Each additional fill requires documentation of the patient's use of the previous supply of Firazyr, as well as, documentation of symptom relief with the use of Firazyr. For example, if the member has two syringes on hand, then Priority Health will authorize a fill of one syringe to total three syringes on hand as long as Firazyr showed benefit for the patient.

NOTE: Priority Health may require you get a second opinion confirming your diagnosis prior to covering this medication.

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 09/2018
Last reviewed 09/2019

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Hereditary angioedema type I or II
- ☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. Have 2 sets of C4, C1-INH protein, and C1-INH function lab results been submitted to Priority Health?

- ☐ Yes
- ☐ No; *Rationale for use:* _____

C. Is the patient currently taking an ACE inhibitor?

- ☐ Yes
- ☐ No

Rationale for use: _____

D. Does the patient have a history of ischemic heart disease?

- ☐ Yes
- ☐ No

D. Will the patient be using Firazyr for acute or prophylactic treatment?

- ☐ Acute
- ☐ Prophylactic

E. Is the patient refractory to one optimized prophylactic treatment that includes an androgen and/or antifibrinolytic?

- ☐ Yes

Drug: _____ **Dose**: _____ **Dates of use**: _____

Drug: _____ **Dose**: _____ **Dates of use**: _____

Request to continue a previously authorized approval

Priority Health Precertification Documentation

A. What are the dates of injection for the last three Firazyr syringes dispensed? (Please provide accompanying documentation)

Dose: _____
Dose: _____
Dose: _____

B. Has documentation been submitted showing the patient has had symptom relief from the use of Firazyr?

- ☐ Yes
- ☐ No; *Rationale for use:* _____

Additional information

Note: Firazyr is not covered in combination with Kalbitor or Berinert.

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Updated 09/2018
Last reviewed 09/2019