OPTIMA HEALTH PLAN

PHARMACY/MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-844-723-2094. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

Drug Requested: **Firazyr®** (icatibant) **(J1744)** ***(Medical)***

DRUG INFORMATION**: **Complete the information below. If incomplete, authorization process will be delayed.

Drug Form/Strength/Quantity: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code**: _____

Dosing Limit*: *(see below)

A. Quantity Limit (max daily dose) - Pharmacy Benefit: Firazyr 30mg/3ml vial: 3 subcutaneous pen per 28 days

B. Max Units (per dose and over time) - Medical Benefit: 90 billable units per 28 days; 1mg = 1billable

- J1744 30mg/3mL vial: 1mg=1billable ***AND*** NDC 54092-0702-xx 30mg
- **Coverage is provided for *12 months* and will be *eligible* for renewal**

CLINICAL CRITERIA*: *All boxes that apply must be checked or authorization process will be delayed.

Initial Approval Criteria:

I. Treatment of acute attacks of Hereditary Angioedema (HAE):

- ❑ Patient must be at least 18 years of age; **AND**
- ❑ 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);

AND

- ❑ Confirmation the patient is avoiding the following possible triggers for HAE attacks:
  - ❑ Helicobacter pylori infections (confirmed by lab test)
  - ❑ Estrogen-containing oral contraceptive agents OR hormone replacement therapy
  - ❑ Antihypertensive agents containing ACE inhibitors

II.A. ❑ **Patient has the following clinical presentation consistent with HAE I:**

- ❑ 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); **AND**
- ❑ Low C4 level (C4 below the lower limit of normal as defined by the laboratory performing the test);

AND

- ❑ Low C1-INH functional level (C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test); **AND**
- ❑ Patient has a family history of HAE; **OR**
- ❑ Normal C1q level; **OR**

II.B. ❑ **Patient has the following clinical presentation consistent with HAE II:**

- ❑ Normal to elevated C1-INH antigenic level; **AND**
- ❑ Low C4 level (C4 below the lower limit of normal as defined by the laboratory performing the test); **AND**
- ❑ Low C1-INH functional level (C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test); **OR**

(continued on next page)

II.C. ❑ **Patient has the following clinical presentation consistent with HAE III:**

- ❑ Normal C1-INH antigenic level); **AND**
- ❑ Normal C4 level; **AND**
- ❑ Normal C1-INH functional level; **AND**
- ❑ Patient has a known HAE causing C1-INH mutation (i.e., mutation of coagulation factor XII gene); **OR**
- ❑ Patient has a family history of HAE; **AND**

Renewal Criteria:

- ❑ Patient must continue to meet the criteria in sections I & II.A-C; **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 hypersensitivity reactions.

Medication being provided by (check applicable box below):

❑ **Physician's office**

OR

❑ **Specialty Pharmacy*:*** ❑ **PropriumRx**

*****Use of samples to initiate therapy does not meet step edit/preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee:** 12/12/2016
REVISED/UPDATED: ~~3/28/2017;~~ **7/24/2017**;