

Icatibant (FIRAZYR)

Criteria for Use

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VA Pharmacy Services and National Formulary Committee

The following recommendations are based on medical evidence, clinician input, and expert opinion. The content of the document is dynamic and will be revised as new information becomes available. The purpose of this document is to assist practitioners in clinical decision-making, to standardize and improve the quality of patient care, and to promote cost-effective drug prescribing. THE CLINICIAN SHOULD USE THIS GUIDANCE AND INTERPRET IT IN THE CLINICAL CONTEXT OF THE INDIVIDUAL PATIENT. INDIVIDUAL CASES THAT ARE EXCEPTIONS TO THE EXCLUSION AND INCLUSION CRITERIA SHOULD BE ADJUDICATED AT THE LOCAL FACILITY ACCORDING TO THE POLICY AND PROCEDURES OF ITS P&T COMMITTEE AND PHARMACY SERVICES.

The Product Information should be consulted for detailed prescribing information.

Exclusion Criteria

If ANY of the following are selected, the patient will NOT meet criteria for icatibant.

- ☐ Concomitant use with another acute therapy agent for HAE (e.g., ecallantide or sebetralstat)

Inclusion Criteria

All the following must be selected to meet criteria.

- ☐ Restricted to VA / VA Community Care allergy/immunology, dermatology, or emergency medicine providers or locally designated expert
- ☐ Suspected bradykinin-mediated angioedema

Other Justification

- ☐ _____

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