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Prior Authorization Guideline

Guideline Name	Icatibant

Guideline Note:

Effective Date:	7/1/2026

1 . Criteria

Product Name:Generic icatibant	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hereditary angioedema (HAE) confirmed by one of the following:

1.1 C1-INH antigenic level below the lower limit of normal

OR

1.2 C1-INH functional level below the lower limit of normal

OR

1.3 Normal C1-INH levels and one of the following:

- Confirmed presence of variant(s) in the gene(s) for factor XII (F12), angiopoietin-1 (ANGPT1), plasminogen (PLG), kininogen-1 (KNG1), myoferlin (MYOF), and heparan sulfate-glucosamine 3-Osulfotransferase 6 (HS3ST6)
- Recurring angioedema attacks that are refractory to high-dose antihistamines

AND

2 - History of attacks that are considered severe with swelling of the face, throat or gastrointestinal tract that significantly interrupts usual daily activity despite short-term symptomatic treatment

AND

3 - Patient has been evaluated for triggers of HAE attacks and is maximally managed for avoidance of those triggers (such as stress, hormonal changes, dental surgery, trauma, medications including ACE inhibitors and estrogen)

Product Name:Generic icatibant	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Medication has been effective at treating HAE attacks