Ekterly (sebetralstat)

Disclaimer

Clinical guidelines are developed and adopted to establish evidence-based clinical criteria for utilization management decisions. Clinical guidelines are applicable according to policy and plan type. The Plan may delegate utilization management decisions of certain services to third parties who may develop and adopt their own clinical criteria.

Coverage of services is subject to the terms, conditions, and limitations of a member's policy, as well as applicable state and federal law. Clinical guidelines are also subject to in-force criteria such as the Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) for Medicare Advantage plans. Please refer to the member's policy documents (e.g., Certificate/Evidence of Coverage, Schedule of Benefits, Plan Formulary) or contact the Plan to confirm coverage.

Summary

Hereditary angioedema (HAE) is a rare, autosomal dominant disease that causes swelling, pain and inflammation in various areas of the body including the face, hands, feet, throat, stomach, and bowels. HAE can be caused by a reduced amount or decreased function of C1 esterase inhibitor protein, a regulator of inflammatory pathways.

HAE can be divided into two main types:

- HAE due to C1 inhibitor (HAE-C1INH) deficiency, which is further divided into Type 1 HAE (deficient levels of C1INH protein and function, accounts for about 80% to 85% of HAE cases) and Type 2 HAE (normal level of C1INH protein that is dysfunctional, accounts for about 15% to 20% of HAE cases
- HAE with normal C1-Inhibitor (HAE-nC1-INH) , previously referred to as HAE Type 3, rarest type.

Ekterly is a plasma kallikrein inhibitor indicated for the treatment of acute attacks of HAE in adult and pediatric patients aged 12 years and older. The maximum recommended dosage is 1,200 mg (4 tablets) in any 24-hour period.

Definitions

"C1 inhibitor" refers to an enzyme that functions as a major anti-inflammatory protein in the body. People who have HAE have low levels of C1 inhibitor in their body.

"C4" or "Complement 4" refers to an enzyme that is involved in the inflammatory response. Alterations in C1 inhibitor can result in low levels of C4 in people who have HAE.

"Documentation" refers to written information, including but not limited to:

- Up-to-date chart notes, relevant test results, and/or relevant imaging reports to support diagnoses; or
- Prescription claims records, and/or prescription receipts to support prior trials of formulary alternatives.

"Hereditary angioedema (HAE)" refers to a rare, inherited disease that causes swelling, pain and inflammation in various areas of the body including the face, hands, feet, throat, stomach, and bowels.

"No evidence" indicates that the reviewer has not identified any records of the specified item or condition within the submitted materials or claims history. In the absence of such evidence, the member is considered eligible. If any evidence of the item or condition is present upon review of the request, the member does not qualify.

"[s]" indicates state mandates may apply.

Clinical Indications

Medical Necessity Criteria for Clinical Review

General Medical Necessity Criteria

The Plan considers Ekterly (sebetralstat) medically necessary when ALL of the following criteria are met:

1. Prescribed by or in consultation with an allergist, hematologist, immunologist, or other specialist experienced in the diagnosis and management of hereditary angioedema (HAE)*; AND*
2. The member is 12 years of age or older; *AND*
3. Ekterly (sebetralstat) is being prescribed at a dose and frequency that is within FDA approved labeling; *AND*
4. The member meets the applicable Medical Necessity Criteria for Initial Clinical Review or Subsequent Clinical Review listed below.

Medical Necessity Criteria for Initial Clinical Review

Initial Indication-Specific Criteria

Treatment of Acute Attacks of Hereditary Angioedema (HAE)

The Plan considers Ekterly (sebetralstat) medically necessary when [ALL of the following criteria are met:

1. The member meets the above General Medical Necessity Criteria; *AND*
2. The member has a diagnosis of HAE; *AND*
3. The diagnosis is supported by ONE of the following documentation:
    a. Clinically appropriate low levels (as defined by the laboratory reference values) of ALL of the following:
        i. Low complement C4 (either at baseline or during an attack)*; and*
        ii. Low C1 esterase inhibitor (C1-INH) antigenic protein level (Type 1 HAE) OR functional level (Type 2 HAE)*; or*
    b. Documented normal or near normal C4, C1-INH antigen, and C1-INH function AND ONE of the following:
        i. Demonstration of a mutation (e.g., in the factor XII, plasminogen, angiopoietin-1, SERPING1, kininogen gene, Myoferlin [MYOF], or Heparan sulfate glucosamine 3-O-sulfotransferase 6 [HS3ST5]) associated with HAE*; or*
        ii. A positive family history of recurrent angioedema or C1-INH deficiency and documented lack of efficacy of high-dose antihistamine therapy (e.g., cetirizine at 40 mg/day or the equivalent)*; AND*
4. The member has a documented history of hereditary angioedema attack(s) (e.g., airway swelling, severe abdominal pain, facial swelling, nausea and vomiting, painful facial distortion)*; AND*
5. The member is unable to use, or has tried and failed generic icatibant (Firazyr)[s]; *AND*
6. No evidence that the member's angioedema is caused by other conditions (e.g., angiotensin-converting enzyme inhibitor [ACE-I] induced angioedema, angioedema related to an estrogen-containing drug, or allergic angioedema).

If the above prior authorization criteria are met, the requested product will be authorized for up to 12-months.[s]

Continued Care

Medical Necessity Criteria for Subsequent Clinical Review

Subsequent Indication-Specific Criteria

Treatment of Acute Attacks of Hereditary Angioedema (HAE)

The Plan considers Ekterly (sebetralstat) medically necessary when ALL of the following criteria are met:

1. The member meets the above applicable General Medical Necessity Criteria; *AND*
2. The member has experienced a reduction in severity and/or duration of acute attacks*; AND*
3. Prophylaxis should be considered based on the attack frequency, attack severity, comorbid conditions, and member's quality of life.

If the above reauthorization criteria are met, the requested product will be authorized for up to 12-months.[s]

Experimental or Investigational / Not Medically Necessary[s]

Ekterly (sebetralstat) for any other indication or use is considered not medically necessary by the Plan, as it is deemed to be experimental, investigational, or unproven. Non-covered indications include, but are not limited to, the following:

- HAE prophylaxis

References

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