

<b>Policy Title:</b>	Kalbitor (ecallantide) (Subcutaneous)		
		<b>Department:</b>	PHA
<b>Effective Date:</b>	01/01/2020		
<b>Review Date:</b>	10/02/19, 12/18/19, 1/22/20, 5/06/21, 2/10/2022, 3/16/2023, 12/07/2023, 01/10/2024		

**Purpose:** To support safe, effective, and appropriate use of Kalbitor (ecallantide).

**Scope:** Medicaid, Commercial, Medicare-Medicaid Plan (MMP)

**Policy Statement:**

Kalbitor (ecallantide) is covered under the Medical Benefit when used within the following guidelines. Use outside of these guidelines may result in non-payment unless approved under an exception process.

**Procedure:**

Coverage of Kalbitor (ecallantide) will be reviewed prospectively via the prior authorization process based on criteria below.

**Initial Criteria:**

- Member is 12 years of age or older; AND
- Kalbitor is being used for treatment of acute hereditary angioedema (HAE) attacks
- Medication is prescribed by, or in consultation with allergist/immunologist or a physician who specializes in the treatment of HAE or related disorders; AND Member has history of moderate to severe cutaneous attacks (without concomitant hives) OR abdominal attacks OR mild to severe airway swelling attacks of HAE (i.e., debilitating cutaneous/gastrointestinal symptoms OR laryngeal/pharyngeal/tongue swelling); AND
- Patient has documented diagnosis of HAE type I or type II and meets one of the following:
  - Member has C1 inhibitor deficiency or dysfunction as confirmed by laboratory testing and meets of the following criteria:
    - C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test, OR
    - Normal C1-INH antigenic level and a low C1-INH functional level (functional C1-INH less than 50% or C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test); OR
  - Member has normal C1 inhibitor as confirmed by laboratory testing and meets one of the following criteria:
    - Member has an F12, angiotensin-1, plasminogen, or kininogen-1 (KNG1) gene mutation as confirmed by genetic testing, OR

- Member has a documented family history of angioedema, and the angioedema was refractory to a trial of high-dose antihistamine (e.g., cetirizine) for at least one month.
- Dose does not exceed FDA approved labeling; AND
- The requested medication will not be used in combination with other products indicated for acute treatment of HAE attacks (e.g., Ruconest, Haegarda, or Icatibant)
- MMP members who have previously received this medication within the past 365 days are not subject to Step Therapy Requirements.

***Continuation of Therapy Criteria:***

- Patient continues to meet initial criteria; AND
- Patient has experienced reduction in severity and duration of attacks since starting treatment; AND
- Documentation supporting a positive clinical response to therapy with Kalbitor (e.g., chart notes, medical records)

**Coverage durations:**

- Initial coverage: 6 months
- Continuation of therapy coverage: 6 months

Per §§ 42 CFR 422.101, this clinical medical policy only applies to INTEGRITY in the absence of National Coverage Determination (NCD) or Local Coverage Determination (LCD).

**Dosage/Administration:**

Indication	Dose	Maximum dose (1 billable unit = 1 mg)
HAE	30 mg injected subcutaneously by a health care professional in three 10 mg injections. An additional dose of 30 mg may be administered if the attack persists. Not to exceed a total of two 30 mg doses (60 mg) in 24 hours	240 billable units per 28 days

**Investigational use:** All therapies are considered investigational when used at a dose or for a condition other than those that are recognized as medically accepted indications as defined in any one of the following standard reference compendia: American Hospital Formulary Service Drug

information (AHFS-DI), Thomson Micromedex DrugDex, Clinical Pharmacology, Wolters Kluwer Lexi-Drugs, or Peer-reviewed published medical literature indicating that sufficient evidence exists to support use. Neighborhood does not provide coverage for drugs when used for investigational purposes.

**Applicable Codes:**

Below is a list of billing codes applicable for covered treatment options. The below tables are provided for reference purposes and may not be all-inclusive. Requests received with codes from tables below do not guarantee coverage. Requests must meet all criteria provided in the procedure section.

The following HCPCS/CPT codes are:

HCPCS/CPT Code	Description
J1290	Injection, ecallantide, 1 mg

References:

1. Kalbitor [package insert]. Burlington, MA: Dyax Corp.; October 2022. Accessed November 2023.
2. Bowen T, Cicardi M, Farkas H, et al. 2010 International consensus algorithm for the diagnosis, therapy, and management of hereditary angioedema. *Allergy Asthma Clin Immunol.* 2010;6(1):24.
3. Cicardi M, Bork K, Caballero T, et al. Hereditary Angioedema International Working Group. Evidence-based recommendations for the therapeutic management of angioedema owing to hereditary C1 inhibitor deficiency: consensus report of an International Working Group. *Allergy.* 2012;67:147-157.
4. Zuraw BL, Banerji A, Bernstein JA, et al. US Hereditary Angioedema Association Medical Advisory Board 2013 recommendations for the management of hereditary angioedema due to C1 inhibitor deficiency. *J Allergy Clin Immunol: In Practice.* 2013; 1(5): 458-467.
5. Zuraw BL, Bork K, Binkley KE, et al. Hereditary angioedema with normal C1 inhibitor function: consensus of an international expert panel. *Allergy Asthma Proc.* 2012; 33(6):S145-S156.
6. Maurer M, Magerl M, Ansotegui I, et al. The international WAO/EAACI guideline for the management of hereditary angioedema – the 2017 revision and update. *Allergy.* 2018;00:1-22.
7. Lang DM, Aberer W, Bernstein JA, et al. International consensus on hereditary and acquired angioedema. *Ann Allergy Asthma Immunol.* 2012; 109:395-202.
8. Cicardi M, Aberer W, Banerji A, et al. Classification, diagnosis, and approach to treatment for angioedema: consensus report from the Hereditary Angioedema International Working Group. *Allergy.* 2014;69: 602-616.
9. Bowen T. Hereditary angioedema: beyond international consensus – circa December 2010 – The Canadian Society of Allergy and Clinical Immunology Dr. David McCourtie Lecture. *Allergy Asthma Clin Immunol.* 2011;7(1):1.
10. Bernstein J. Update on angioedema: Evaluation, diagnosis, and treatment. *Allergy and Asthma Proceedings.* 2011;32(6):408-412.

11. Longhurst H, Cicardi M. Hereditary angio-edema. *Lancet*. 2012;379:474-481.
12. Clinical Consult: Caremark Clinical Programs Review: Focus on Hereditary Angioedema Clinical Programs. June 2015.
12. Farkas H, Martinez-Saguer I, Bork K, et al. International consensus on the diagnosis and management of pediatric patients with hereditary angioedema with C1 inhibitor deficiency. *Allergy*. 2017;72(2):300-313.