Clinical Policy: Sebetralstat (Ekterly)

Reference Number: CP.PHAR.723
Effective Date: 07.03.25
Last Review Date: 08.26
Line of Business: Commercial, HIM/ICHRA, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Sebetralstat (Ekterly®) is plasma kallikrein inhibitor.

FDA Approved Indication(s)

Ekterly is indicated for the treatment of acute attacks of hereditary angioedema (HAE) in adult and pediatric patients aged 12 years of age and older.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Ekterly is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Hereditary Angioedema (must meet all)**:**

1. Diagnosis of HAE confirmed by both of the following (a and b):
   a. History of recurrent angioedema;
   b. Low C4 level and low C1-INH antigenic or functional level (*see Appendix D*);
2. Prescribed by or in consultation with a hematologist, allergist, or immunologist;
3. Age ≥ 12 years;
4. Prescribed for treatment of acute HAE attacks;
5. For members age ≥ 18 years: Failure of icatibant^ (generic Firazyr®), unless contraindicated or clinically significant adverse effects are experienced;*
   ^Prior authorization may be required for icatibant
   **For Illinois HIM requests, the step therapy requirements above do not apply per IL HB 5395*
6. Member is not using Ekterly in combination with another FDA-approved product for treatment of acute HAE attacks (e.g., Berinert®, icatibant [Firazyr], Kalbitor®, Ruconest®);
7. Request does not exceed 4 doses per month;
8. Dose does not exceed both of the following (a and b):
   a. 600 mg (2 tablets) per dose;
   b. Up to 2 doses (4 tablets) administered in a 24-hour period.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Hereditary Angioedema (must meet all)**:**
1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B)*;
2. Member is responding positively to therapy;
3. Member is not using Ekterly in combination with another FDA-approved product for treatment of acute HAE attacks (e.g., Berinert, icatibant [Firazyr], Kalbitor, Ruconest);
4. Request does not exceed 4 doses per month;
5. If request is for a dose increase, new dose does not exceed both of the following (a and b):
   a. 600 mg (2 tablets) per dose;
   b. Up to 2 doses (4 tablets) administered in a 24-hour period.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or

b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CI-INH: C1 esterase inhibitor
C4: complement component 4
FDA: Food and Drug Administration
HAE: hereditary angioedema
HAE-nl-C1INH: hereditary angioedema with normal C1 inhibitor

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
icatibant (Firazyr)	30 mg SC in the abdominal area; if response is inadequate or symptoms recur, additional injections of 30 mg may be administered at intervals of at least 6 hours. Do not administer more than 3 injections in 24 hours.	90 mg/24 hours

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

None reported

Appendix D: General Information

- Diagnosis of HAE:
  - There are two classifications of HAE: HAE with C1-INH deficiency (HAE-C1INH, further broken down into Type 1 and Type II) and HAE with normal C1-INH (also known as HAE-nl-C1INH). HAE-nl-C1INH was previously referred to as type III HAE, but this term is obsolete and should not be used.

- There is insufficient data regarding the use of sebetralstat in HAE-nl-C1INH. The KONFIDENT clinical trial excluded concurrent diagnosis of HAE with normal CI-INH. The US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema does not make any explicit recommendation for use in HAE-nl-C1INH, and there are no randomized controlled trials evaluating such use.
- In both Type 1 (~85% of cases) and Type II (~15% of cases), C4 levels are low. C1-INH antigenic levels are low in Type I while C1-INH functional levels are low in Type II. Diagnosis of Type I and II can be confirmed with laboratory tests. Reference ranges for C4 and C1-INH levels can vary across laboratories (see below for examples); low values confirming diagnosis are those which are below the lower end of normal.

Laboratory Test & Reference Range	Mayo Clinic	Quest Diagnostics	LabCorp
C4	14-40 mg/dL	13-57 mg/dL (age- and gender-specific ranges)	10-38 mg/dL (age- and gender-specific ranges)
C1-INH, antigenic	19-37 mg/dL	21-39 mg/dL	21-39 mg/dL
C1-INH, functional	Normal: > 67% Equivocal: 41-67% Abnormal: < 41%	Normal: ≥ 68% Equivocal: 41-67% Abnormal: ≤ 40%	Normal: > 67% Equivocal: 41-67% Abnormal: < 41%

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Treatment of acute HAE attacks	600 mg PO at the earliest recognition of an acute HAE attack; a second dose of 600 mg may be taken at least 3 hours after the first dose if response is inadequate, or if symptoms worsen or recur. Do not administer more than 1,200 mg in 24 hours	1,200 mg/24 hours

VI. Product Availability

Tablet: 300 mg

VII. References

1. Ekterly Prescribing Information. Cambridge, MA: KalVista Pharmaceuticals, Inc.; July 2025. Available at: www.ekterly.com. Accessed May 13, 2026.
2. Cicardi M, Bork K, Caballero T, et al. 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(2): 147-157.
3. 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(5): 602-616.

4. Zuraw BL, Bernstein JA, Lang DM, et al. A focused parameter update: hereditary angioedema, acquired C1 inhibitor deficiency, and angiotensin-converting enzyme inhibitor-associated angioedema. *J Allergy Clin Immunol*. 2013; 131(6): 1491-1493.
5. Maurer M, Magerl M, Betschel S, et al. The international WAO/EAACI guideline for the management of hereditary angioedema-The 2021 revision and update. *Allergy*. 2022;77(7):1961-1990.
6. Busse PJ, Christiansen SC, Reidl MA, et al. US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema. *J Allergy Clin Immunol*. 2021; 9(1): 132-150.e3.
7. Farkas H, Martinez-Saguer I, Bork K, et al; Hereditary Angioedema Working Group (HAWK Group). International Guideline on the Diagnosis and Management of Pediatric Patients With Hereditary Angioedema. *Allergy*. 2026 Jan 30. doi: 10.1111/all.70207.
8. Mayo Clinic Laboratories [internet database]. Rochester, Minnesota: Mayo Foundation for Medical Education and Research. Updated periodically. Accessed May 13, 2026.
9. Quest Diagnostics® [internet database]. Updated periodically. Accessed May 13, 2026.
10. LabCorp [internet database]. Burlington, North Carolina: Laboratory Corporation of America. Updated periodically. Accessed May 13, 2026.

Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J8499	Prescription drug, oral, non chemotherapeutic, nos

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created pre-emptively	02.11.25	05.25
RT4: Drug is now FDA approved – criteria updated per FDA labeling; added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.	07.09.25	
HCPCS code added [J8499].	09.11.25	
2Q 2026 annual review: extended initial approval duration from 6 months to 12 months for a chronic condition; references reviewed and updated. Added ICHRA line of business.	03.31.26	05.26
3Q 2026 annual review: added quantity limit; references reviewed and updated.	05.13.26	08.26

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program

approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

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This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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