UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 2374-1
Program	Prior Authorization/Medical Necessity
Medication	Ekterly® (sebetralstat)
P&T Approval Date	8/2025
Effective Date	11/1/2025

1. Background:

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

2. Coverage Criteria [a]:

A. Initial Authorization

1. Ekterly will be approved based on **all** of the following criteria:

a. Diagnosis of hereditary angioedema (HAE) as confirmed by **one** of the following:

(1) C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by **one** of the following (per laboratory standard):

(a) C1-INH antigenic level below the lower limit of normal

(b) C1-INH functional level below the lower limit of normal

-OR-

(2) HAE with normal C1 inhibitor levels and **one** of the following:

(a) Confirmed presence of variant(s) in the gene(s) for factor XII, angiopoietin-1, plasminogen-1, kininogen-1, myoferlin, or heparan sulfate-glucosamine 3-O-sulfotransferase 6

(b) Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema

(c) Recurring angioedema attacks that are refractory to high-dose antihistamines with unknown background de-novo mutation(s) (i.e., no family history) (HAE-unknown)

-AND-

b. **Both** of the following:

(1) Prescribed for the acute treatment of HAE attacks

(2) Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Berinert, Firazyr, icatibant, Kalbitor, Ruconest, Sajazir)

-AND-

c. Prescribed by **one** of the following:

(1) Immunologist
(2) Allergist

Authorization will be issued for 12 months.

B. Reauthorization

1. Ekterly will be approved based on **all** of the following criteria:

a. Documentation of positive clinical response to Ekterly therapy

-AND-

b. **Both** of the following:

(1) Prescribed for the acute treatment of HAE attacks

-AND-

(2) Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Berinert, Firazyr, icatibant, Kalbitor, Ruconest, Sajazir)

-AND-

c. Prescribed by **one** of the following:

(1) Immunologist
(2) Allergist

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Programs:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Ekterly [package insert]. Cambridge, MA: KalVista Pharmaceuticals, Inc; July 2025.
2. 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 Jan 10.
3. Wu, E. Hereditary angioedema with normal C1 inhibitor. In: UpToDate, Saini, S (Ed), UpToDate, Waltham, MA, 2025.
4. Busse, P., Christiansen, S., Riedl, M., et. al. "US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema." *The Journal of Allergy and Clinical Immunology.* 2020 September 05.
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. doi:10.1111/all.15214

Program	Prior Authorization/Medical Necessity – Ekterly® (sebetralstat)
Change Control	
8/2025	New program.