



Kalbitor® (ecallantide) (Subcutaneous)

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I. Length of Authorization

Coverage will be provided for 12 weeks and is eligible for renewal (unless otherwise specified).

The cumulative amount of medication(s) the patient has on-hand, indicated for the acute treatment of HAE, will be taken into account when authorizing. The authorization will provide a sufficient quantity in order for the patient to have a cumulative amount of HAE medication on-hand in order to treat up to 4 acute attacks per 4 weeks for the duration of the authorization (unless otherwise specified).

II. Dosing Limits

A. Quantity Limit (max daily dose) [NDC unit]:

- Kalbitor 10 mg vial: 24 vials per 28 days

B. Max Units (per dose and over time) [HCPCS Unit]:

- 240 billable units per 28 days

III. Initial Approval Criteria¹⁻¹⁵

Coverage is provided in the following conditions:

Universal Criteria:

- Must be prescribed by, or in consultation with, a specialist in: allergy, immunology, hematology, pulmonology, or medical genetics; **AND**
- Confirmation the patient is avoiding the following possible triggers for HAE attacks:
 - Estrogen-containing oral contraceptive agents AND hormone replacement therapy; **AND**
 - Antihypertensive agents containing ACE inhibitors; **AND**

Treatment of acute attacks of Hereditary Angioedema (HAE) †

- Patient must be at least 12 years of age; **AND**

- Patient has a 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 one of the following clinical presentations consistent with a HAE subtype, which must be confirmed by repeat blood testing:

HAE I (C1-Inhibitor deficiency)
<ul style="list-style-type: none"> • Low C1 inhibitor (C1-INH) antigenic level (C1-INH antigenic level below the lower limit of normal as defined by the laboratory performing the test); AND • Low C4 level (C4 below the lower limit of normal as defined by the laboratory performing the test); AND • Low C1-INH functional level (C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test); AND <ul style="list-style-type: none"> ○ Patient has a family history of HAE; OR ○ Acquired angioedema has been ruled out (i.e., patient onset of symptoms occur prior to 30 years old, normal C1q levels, patient does not have underlying disease such as lymphoma or benign monoclonal gammopathy [MGUS], etc.)
HAE II (C1-Inhibitor dysfunction)
<ul style="list-style-type: none"> • Normal to elevated C1-INH antigenic level; AND • Low C4 level (C4 below the lower limit of normal as defined by the laboratory performing the test); AND • Low C1-INH functional level (C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test)
HAE with normal C1INH (formerly known as HAE III)
<ul style="list-style-type: none"> • Normal C1-INH antigenic level; AND • Normal C4 level; AND • Normal C1-INH functional level; AND • Repeat blood testing <u>during an attack</u> has confirmed the patient does not have abnormal lab values indicative of HAE I or HAE II; AND • Either of the following: <ul style="list-style-type: none"> ○ Patient has a known HAE-causing mutation (e.g., mutation of coagulation factor XII gene [F12 mutation], mutation in the angiotensin-1 gene, mutation in the plasminogen gene, etc.); OR ○ Patient has a family history of HAE and documented evidence of lack of efficacy of chronic high-dose antihistamine therapy (e.g. <i>cetirizine standard dosing at up to four times daily or an alternative equivalent, given for at least one month or an interval long enough to expect three or more angioedema attacks</i>) AND corticosteroids; AND • Patient had an inadequate response or intolerance to an adequate trial of prophylactic therapy with an antifibrinolytic agent (e.g., tranexamic acid (TXA) or aminocaproic acid) and/or a 17α-alkylated androgen (e.g., danazol) unless contraindicated. Female patients may derive additional benefit from progestins^{16,17,18} [Note: if the clinical status of the patient warrants on-demand treatment, this criterion will be waived, and sufficient on-demand therapy approved (if all other criteria are met) in order to treat two acute attacks of HAE. Approval of additional on-demand treatment will be contingent upon either fulfilling this criterion or case by case review in instances where the criteria has not been fulfilled and on-demand therapy is required as a bridge in the interim.]

† FDA Approved Indication(s)

IV. Renewal Criteria¹

Coverage can be renewed based upon the following criteria:

- Patient must continue to meet the universal and other indication-specific relevant criteria identified in section III; **AND**
- Significant improvement in severity and duration of attacks have been achieved and sustained; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include hypersensitivity reactions, etc.; **AND**
- The cumulative amount of medication(s) the patient has on-hand, indicated for the acute treatment of HAE, will be taken into account when authorizing. The authorization will provide a sufficient quantity in order for the patient to have a cumulative amount of HAE medication(s) on-hand in order to treat up to 4 acute attacks per 4 weeks for the duration of the authorization (unless otherwise specified).

V. Dosage/Administration

Indication	Dose
Acute Hereditary Angioedema (HAE) attack	30 mg injected subcutaneously by a healthcare 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.

VI. Billing Code/Availability Information

Jcode:

- J1290 – Injection, ecallantide, 1 mg; 1 billable unit = 1 mg

NDC:

- Kalbitor 10 mg/mL; carton of 3 single-use vials: 47783-0101-xx

VII. References

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Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
D84.1	Defects in the complement system

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: <http://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx>. Additional indications may be covered at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD): N/A

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	Applicable State/US Territory	Contractor
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA, LLC
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA, LLC
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC