MEDICAL MUTUAL®

Drug Policy

Policy:	**201021-MRX (10-23)**	**Initial Effective Date:** **12/21/2010** **Annual Review Date:** **08/20/2024** **Last Revised Date:** **08/20/2024**
Code(s):	**HCPCS J1290**	
SUBJECT:	**Kalbitor (ecallantide)**	

☒Subject to Site of Care

Prior approval is required for some or all procedure codes listed in this Corporate Drug Policy.

Initial and renewal requests for the medication(s) listed in this policy are subject to site of care management. When billed under the medical benefit, administration of the medication will be restricted to a non-hospital facility-based location (i.e., home infusion provider, provider's office, free-standing ambulatory infusion center) unless the member meets the site of care exception criteria. To view the exception criteria and a list of medications subject to site of care management please click here.

I. Length of Authorization

Coverage will be provided for 12 weeks and is eligible for renewal.

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.

II. Dosing Limits

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

– Kalbitor 10 mg single-use 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 Criteria [1]

Coverage is provided in the following conditions:

- Patient is at least 12 years of age; **AND**

Universal Criteria [1,13,18]

- 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 or angiotensin II receptor blockers (ARBs); **AND**
  - Dipeptidyl peptidase IV (DPP-IV) inhibitors (e.g., sitagliptin); **AND**
  - Neprilysin inhibitors (e.g., sacubitril); **AND**

Treatment of acute attacks of Hereditary Angioedema (HAE) † Φ [1,13,18,19,21]

- 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 (treatment for acute attack should not be delayed for confirmatory testing):

HAE I (C1-Inhibitor deficiency) § [13,18,19,21]
• 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** o Patient has a family history of HAE; **OR** o Acquired angioedema has been ruled out (i.e., patient onset of symptoms occur prior to 30 years of age, normal C1q levels, patient does not have underlying disease such as lymphoma or benign monoclonal gammopathy [MGUS], etc.)
HAE II (C1-Inhibitor dysfunction) § [18,21]

• 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) § [18,19,21]
• Normal to near normal C1-INH antigenic level; **AND** • Normal to near normal C4 level; **AND** • Normal to near normal C1-INH functional level; **AND** • Repeat blood testing during an attack has confirmed the patient does not have abnormal lab values indicative of HAE I or HAE II; **AND** • Either of the following: ○ Patient has a known HAE-causing mutation (e.g., mutation of coagulation factor XII gene, mutation in the angiopoietin-1 gene, mutation in the plasminogen gene, mutation in the kininogen 1 gene, mutation in the myoferlin gene, mutation in the heparan sulfate 3-O-sulfotransferase 6 gene, etc.); **OR** ○ Patient has a family history of HAE and documented lack of efficacy of chronic high-dose antihistamine therapy (*e.g. 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*) AND corticosteroids with or without omalizumab

† FDA Approved Indication(s); ‡ Compendia Recommended Indication(s); **Φ** Orphan Drug

IV. Renewal Criteria [1]

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 serious hypersensitivity reactions, including anaphylaxis, 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.

V. Dosage/Administration [1]

Indication	Dose
Treatment of Acute Hereditary Angioedema (HAE) attack	Administer 30 mg 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. ***Note:** Kalbitor should ONLY be administered by a healthcare professional.*

VI. Billing Code/Availability Information

HCPCS Code:

- 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

1. Kalbitor [package insert]. Lexington, MA; Takeda Pharmaceuticals U.S.A.; November 2021. Accessed July 2024.
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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)

The preceding information is intended for non-Medicare coverage determinations. 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 Determinations (NCDs) and/or Local Coverage Determinations (LCDs) may exist and compliance with these policies is req uired where applicable. Local Coverage Articles (LCAs) may also exist for claims payment purposes or to clarify benefit eligibility under Part B for drugs which may be self-administered. The following link may be used to search for NCD, LCD, or LCA documents: https://www.cms.gov/medicare-coverage-database/search.aspx. Additional indications, including any preceding information, may be applied at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD/LCA): 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.

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Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
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
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA
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

Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the drug provided or services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

Prior approval is required for HCPCS Codes J1290

Edits and Denials:

Prior approval: Prior approval is required for ecallantide **(HCPCS Code J1290)**. Requests for prior approval will be authorized by a nurse reviewer if submitted documentation meets criteria outlined within Corporate Medical Policy.

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Requests for prior approval will be forwarded to a qualified physician consultant for review if submitted documentation does not meet criteria outlined within Corporate Medical Policy.