PHARMACY POLICY STATEMENT
Indiana Medicaid

DRUG NAME	Kalbitor (ecallantide)
BILLING CODE	J1290
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient
STATUS	Prior Authorization Required

Kalbitor is a plasma kallikrein inhibitor indicated for treatment of acute attacks of hereditary angioedema (HAE) in patients 12 years of age and older. It must be administered by a healthcare professional because of the risk for anaphylaxis, which is a black box warning for the product.

CareSource considers Kalbitor (ecallantide) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
08/28/2017	New policy for Kalbitor created. Criteria for each type of HAE specified. Criteria of documentation of attacks, discontinuation of meds that can cause HAE, and restriction on combinations with other meds for acute attacks added.
01/20/2021	Updated references. Removed hematology as a specialist. Simplified the diagnostic criteria. Removed log book requirement. Reworded the renewal criteria. Extended initial auth duration to 6 mo and renewal to 12 mo. Removed statement about causative meds. Clarified the dosing. Adjusted quantity limit to allow for repeat doses per label.
07/05/2022	Transferred to new template, updated references, put “icatibant” instead of “Firazyr.”

References:

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