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Section:	Prescription Drugs	**Effective Date:**	April 1, 2026
Subsection:	Hematological Agents	**Original Policy Date:**	August 1, 2025
Subject:	Ekterly	**Page:**	1 of 4

Last Review Date: March 6, 2026

Ekterly

Description

Ekterly (sebetralstat)

Background

Ekterly (sebetralstat) is a competitive, reversible inhibitor of plasma kallikrein. Plasma kallikrein is a serine protease that cleaves high molecular weight kininogen (HK) releasing bradykinin which increases vascular permeability through activation of bradykinin receptors causing edema. Ekterly inhibits the cleavage of HK and reduces production of bradykinin, thereby treating the clinical symptoms of acute, episodic attacks of hereditary angioedema (HAE). Ekterly also inhibits the positive feedback mechanism of kallikrein kinin system by plasma kallikrein, thereby reducing factor XIIA and additional plasma kallikrein generation (1).

Regulatory Status

FDA-approved indication: Ekterly is a plasma kallikrein inhibitor indicated for treatment of acute attacks of hereditary angioedema (HAE) in adult and pediatric patients aged 12 years and older (1).

The safety and effectiveness of Ekterly in pediatric patients less than 12 years of age have not been established (1).

Related policies

Andembry, Berinert, Cinryze, Dawnzera Haegarda, Icatibant, Kalbitor, Orladeyo, Ruconest, Takhzyro

Policy

This policy statement applies to clinical review performed for pre-service (Prior Approval, Precertification, Advanced Benefit Determination, etc.) and/or post-service claims.

Ekterly may be considered **medically necessary** if the conditions indicated below are met.

Ekterly may be considered **investigational** for all other indications.

Prior-Approval Requirements

Age 12 years of age and older

Diagnosis

Patient must have the following:

1. Hereditary Angioedema (HAE) with **ONE** of the following:
    a. Patient has a C1 inhibitor deficiency or dysfunction as confirmed by laboratory testing **AND ALL** of the following:
        i. C4 level below the lower limit of normal as defined by the laboratory performing the test
        ii. C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test **OR** normal C1-INH antigenic level and a low C1-INH functional level (functional C1-INH less than 50% or C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test)
    b. Patient has normal C1 inhibitor as confirmed by laboratory testing **AND ONE** of the following:
        i. F12, angiopoietin-1, plasminogen, or kininogen-1 (KNG1) gene mutation as confirmed by genetic testing
        ii. Documented family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine (e.g., cetirizine) for at least one month

AND ALL of the following:
a. Used for acute attacks of hereditary angioedema

b. **NOT** being used for the routine prevention of hereditary angioedema attacks
c. **NO** dual therapy with another agent for treating acute attacks of hereditary angioedema (e.g., Berinert, Firazyr/Sajazir, Kalbitor, Ruconest)

Prior – Approval *Renewal* Requirements

Age 12 years of age and older

Diagnosis

Patient must have the following:

Hereditary Angioedema (HAE)

AND ALL of the following:
a. Used for acute attacks of hereditary angioedema
b. **NOT** being used for the routine prevention of hereditary angioedema attacks
c. Patient has experienced a reduction in severity and/or duration of hereditary angioedema attacks
d. **NO** dual therapy with another agent for treating acute attacks of hereditary angioedema (e.g., Berinert, Firazyr/Sajazir, Kalbitor, Ruconest)

Policy Guidelines

Pre - PA Allowance

None

Prior - Approval Limits

Duration 12 months

Prior – Approval *Renewal* Limits

Same as above

Rationale

Summary

Ekterly (sebetralstat) is a plasma kallikrein inhibitor indicated for the treatment of acute attacks in adult and adolescent patients with hereditary angioedema (HAE). The safety and effectiveness of Ekterly in pediatric patients less than 12 years of age have not been established (1).

Prior authorization is required to ensure the safe, clinically appropriate, and cost-effective use of Ekterly while maintaining optimal therapeutic outcomes.

References

1. Ekterly [package insert]. Cambridge, MA: KalVista Pharmaceuticals, Inc.; July 2025.

Policy History

Date	Action
August 2025	Addition to PA
December 2025	Annual review
March 2026	Annual review

Keywords

This policy was approved by the FEP® Pharmacy and Medical Policy Committee on March 6, 2026 and is effective on April 1, 2026.