AETNA BETTER HEALTH® Coverage Policy/Guideline			
Name:	Ekterly	Page:	1 of 4
Effective Date:	2/2/2026	Last Review Date:	11/2025
Applies to:	☐Illinois ☒Pennsylvania Kids	☒Maryland ☒New Jersey	☒Florida Kids ☐Kentucky PRMD

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Ekterly under the patient's prescription drug benefit.

Description:

Indications

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

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

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Ekterly

Policy/Guideline:

Documentation for all indications:
The patient is unable to take Berinert and an icatibant product, where indicated, for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication. Documentation is required for approval.

Documentation

Submission of the following information is necessary to initiate the prior authorization review:

- For initial authorization, the following should be documented:
  - C1 inhibitor functional and antigenic protein levels
  - F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) pathogenic variant testing, if applicable
  - Chart notes confirming family history of angioedema and the member's angioedema was refractory to a trial of high-dose antihistamine therapy, if applicable
- For continuation of therapy, chart notes demonstrating a reduction in severity and/or duration of attacks.

Prescriber Specialties
This medication must be prescribed by or in consultation with a prescriber who specializes in the management of HAE.

Coverage Criteria

Hereditary Angioedema (HAE)

Authorization of 12 months may be granted for treatment of acute HAE attacks when the requested medication will not be used in combination with any other medication used for the treatment of acute HAE attacks and either of the following criteria is met at the time of diagnosis:

- Member meets either of the following criteria:
    - Member has C1 inhibitor deficiency or dysfunction as confirmed by laboratory testing and meets one of the following criteria:
        - 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).
    - Member has normal C1 inhibitor as confirmed by laboratory testing and meets one of the following criteria:
        - Member has an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) pathogenic variant as confirmed by genetic testing, or
        - Member has a documented family history of angioedema and the member's angioedema was refractory to a trial of high-dose antihistamine therapy (i.e., cetirizine at 40 mg per day or the equivalent) for at least one month.
- Other causes of angioedema have been ruled out (e.g., angiotensin-converting enzyme inhibitor [ACE-I] induced angioedema, angioedema related to an estrogen-containing drug, allergic angioedema).

Continuation of Therapy

Authorization of 12 months may be granted for continuation of therapy when ALL of the following criteria are met:

- Member meets all requirements in the coverage criteria section.

- Member has experienced a reduction in severity and/or duration of acute attacks.
- Prophylaxis should be considered based on the attack frequency, attack severity, comorbid conditions, and member's quality of life.

Approval Duration and Quantity Restrictions:

Approval: 12 months

References:

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