Louisiana Medicaid
Sebetralstat (Ekterly®)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for sebetralstat (Ekterly®).

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

HAE Medication Use and Minimum Age per Current Drug-Specific Prescribing Information			
Medication	**Brand**	**Use**	**Minimum Age**
Sebetralstat	Ekterly®	Treatment	12

Approval Criteria for Initiation of Therapy

- The recipient has a diagnosis of hereditary angioedema (HAE); **AND**
- The recipient's age on the date of the request is not less than the minimum age recommended in the prescribing information (see table); **AND**
- The requested medication is used as recommended in the prescribing information for either prevention or treatment (see table); **AND**
- The prescriber **states on the request** that the requested medication is not prescribed concurrently with another medication for treatment of HAE; **AND**
- There is no preferred alternative that is the exact same chemical entity, formulation, strength, etc. **AND**
- If the request is for a non-preferred agent - **ONE** of the following is required: (See Hereditary Angioedema on the PDL/NPDL for list of preferred agents)
    - The recipient has had a *treatment failure* with at least one preferred drug that is appropriate to use for the condition being treated; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred drug that is appropriate to use for the condition being treated; **OR**
    - The recipient has *documented contraindication(s)* to the preferred drugs that are appropriate to use for the condition being treated; **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated**.**

Approval Criteria for Continuation of Therapy

- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy; **AND**
- The prescriber **states on the request** that the requested medication is not prescribed concurrently with another medication for treatment of HAE.

Duration of approval for initiation and continuation of therapy: 12 months

Reference

Ekterly (sebetralstat) [package insert]. Cambridge, MA: KalVista Pharmaceuticals, Inc; July 2025. https://www.kalvista.com/ekterly-us-prescribing-information.pdf

Revision / Date	Implementation Date
Policy created / September 2025	April 2026