

CRITERIA FOR PRIOR AUTHORIZATION

Kalbitor® (ecallantide)

PROVIDER GROUP Pharmacy
Professional

MANUAL GUIDELINES The following drug requires prior authorization:
Ecallantide (Kalbitor)

CRITERIA FOR PRIOR AUTHORIZATION FOR ECALLANTIDE: (must meet all of the following)

- Patient must have a diagnosis of Hereditary Angioedema (HAE), with provider submitting documentation that diagnostic testing was completed
- Must be used for the treatment of an acute attack of HAE
- Patient must be 12 years of age or older
- Dose must not exceed 60 mg per 24 hours
- Must be administered by a healthcare professional

LENGTH OF APPROVAL: 12 months