MetroPlus Health

Policy and Procedure

Title: Complement Inhibitors {Soliris (eculizumab) & Ultomiris (ravulizumab-cwvz)	**Division: Medical Management** **Department: Pharmacy**
Approval Date: 6/27/2022	**LOB: Medicaid, HIV SNP, CHP, MetroPlus Gold, Goldcare I&II, Market Plus, Essential, HARP, UltraCare**
Effective Date:6/27/22	**Policy Number: UM-MP338**
Review Date: 6/27/2022	**Cross Reference Number:**
Retired Date:	**Page 1 of 5**

1. POLICY DESCRIPTION:

Complement inhibitors, Soliris (eculizaumab), Ultomiris (ravulizumab-cwvz)

2. RESPONSIBLE PARTIES:

Pharmacy

3. DEFINITIONS:

Soliris is a complement inhibitor indicated for:

- The treatment of patients with paroxysmal nocturnal hemoglobinuria (PNH) to reduce hemolysis.
- The treatment of patients with atypical hemolytic uremic syndrome (aHUS) to inhibit complement-mediated thrombotic microangiopathy.
- The treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AchR) antibody positive
- The treatment of neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive

Ultomiris is a complement inhibitor indicated for:

- The treatment of adult and pediatric patients one month of age and older with paroxysmal nocturnal hemoglobinuria (PNH)
- The treatment of adult and pediatric patients one month of age and older with atypical hemolytic uremic syndrome (aHUS) to inhibit complement mediated thrombotic microangiopathy (TMA)
- The treatment of adult patients with generalized myasthenia gravis (gMG) who are anti-acetylcholine receptor (AChR) antibody-positive

4. POLICY:

<u>INITIAL REQUEST</u>

All initial approvals may be approved up to 6 months

A. Paroxysmal Nocturnal Hemoglobinuria (PNH)
   i. Diagnosis of PNH as confirmed by detecting a deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs) as demonstrated by either of the following:
      i. At least 5% PNH cells

ii. At least 51% of GPI-AP deficient poly-morphonuclear cells
ii. Flow cytometry is used to demonstrate GPI-APs deficiency
iii. Laboratory results, signs/symptoms attributed to PNH (e.g., abdominal pain, anemia, dyspnea, extreme fatiguehemolysis/hemoglobinuria, kidney disease, pulmonary hypertension, etc.)
iv. For Soliris: Documented therapeutic trial of Ultomiris

B. Atypical Hemolytic Uremic Syndrome (aHUS)
   i. Documentation supporting the diagnosis of aHUS by ruling out both of the following:
      i. Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS); and
      ii. Thrombotic thrombocytopenia purpura (TTP)
   ii. Laboratory results, signs, and/or symptoms attributed to aHUS (i.e. thrombocytopenia, microangiopathic hemolysis, thrombotic microangiopathy, acute renal failure
   iii. For Soliris: Documented therapeutic trial of Ultomiris

C. Generalized myasthenia gravis (gMG)
   i. Member is anti-acetylcholine receptor (AchR) antibody positive
   ii. Myasthenia Gravis Foundation of America (MGFA) clinical classification II to IV
   iii. MG activities of daily living (MG-ADL) total score ≥6
   iv. Meets both of the following:
      i. Member has had an inadequate response to at least two immunosuppressive therapies listed below:
         1. azathioprine
         2. cyclosporine
         3. mycophenolate mofetil
         4. tacrolimus
         5. methotrexate
         6. cyclophosphamide
      ii. Member has inadequate response to chronic IVIG AND rituximab
   v. For Soliris: Documented therapeutic trial of Ultomiris

D. Neuromyelitis Optica Spectrum Disorder (NMOSD)- **APPLICABLE TO SOLIRIS ONLY**
   i. Anti-aquaporin-4 (AQP4) antibody positive
   ii. Member exhibits one of the following core clinical characteristics of NMOSD:
      i. Optic neuritis

ii. Acute myelitis
iii. Area postrema syndrome (episode of otherwise unexplained hiccups or nausea and vomiting)
iv. Acute brainstem syndrome
v. Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions
vi. Symptomatic cerebral syndrome with NMOSD-typical brain lesions

iii. The member will not receive the requested drug concomitantly with other biologics for the treatment of NMOSD.

RENEWAL REQUEST

All renewals may be approved up to 12 months

A. All initial conditions of coverage have been met. **AND**
B. The patient's condition has not worsened while on therapy **AND**
C. When used as continued therapy for aHUS: Records reflect that there have been clinical improvement; i.e. increased platelet count or laboratory evidence of reduced hemolysis.
D. When used as continued therapy for PNH: Improvement in hemoglobin levels or Normalization of lactate dehydrogenase levels
E. When used as continued therapy for myasthenia gravis: a positive response to therapy (e.g., improvement in MG-ADL score, changes compared to baseline in Quantitative Myasthenia Gravis (QMG) total score)
F. When used as continued therapy for NMOSD: The member demonstrates a positive response to therapy (e.g., reduction in number of relapses).

5. LIMITATIONS/ EXCLUSIONS:

Soliris/Ultomiris is not indicated for the treatment of patients with Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS).

6. APPLICABLE PROCEDURE CODES:

CPT	Description
J1300	INJECTION, ECULIZUMAB, 10 MG

J1303	Injection, ravulizumab-cwvz, 10 mg

7. APPLICABLE DIAGNOSIS CODES:

CODE	Description
D59.3	Hemolytic-uremic syndrome
D59.5	Paroxysmal nocturnal hemoglobinuria [Marchiafava-Micheli]
G36.0	Neuromyelitis optica [Devic]
G70.00	Myasthenia gravis without (acute) exacerbation

8. REFERENCES:

1. Soliris (eculizumab) [package insert]. Boston, Massachusets: Alexion Pharmaceuticals, Inc. November 2020.
2. Ultomiris [package insert]. Boston, MA: Alexion Pharmaceuticals, Inc.; June 2021.
3. Loirat C, Fakhouri F, Ariceta G, et al. An international consensus approach to the management of atypical hemolytic uremic syndrome in children. *Pediatr Nephrol*. Published online: April 11, 2015.
4. Parker CJ. Management of paroxysmal nocturnal hemoglobinuria in the era of complement inhibitory therapy. *Hematology.* 2011; 21-29.
5. Sanders D, Wolfe G, Benatar M et al. International consensus guidance for management of myasthenia gravis. *Neurology*. 2021; 96 (3) 114-122 .
6. Ultomiris [package insert]. Boston, MA: Alexion Pharmaceuticals, Inc.; June 2021.

REVISION LOG:

REVISIONS	DATE
Creation date	6/17/22
Annual review	6/27/2022

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Approved: Glendon Henry Digitally signed by Glendon Henry Date: 2022.06.28 10:59:23 -04'00' **Date:**	**Approved:** Sanjiv Shah MD Digitally signed by Sanjiv Shah MD Date: 2022.07.06 17:32:16 -04'00' **Date:**
Glendon Henry, MD **Senior Medical Director**	**Sanjiv Shah, MD** **Chief Medical Officer**

Medical Guideline Disclaimer:

 The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Metroplus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria based upon a review of currently available clinical information(including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered andor paid for by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members.

All coding and website links are accurate at time of publication.

MetroPlus Health Plan has adopted the herein policy in providing management, administrative and other services to our members, related to health benefit plans offered by our organization.