

Policy and Procedure

PHARMACY PRIOR AUTHORIZATION POLICY AND CRITERIA ORPTCOTH053.1225	MISCELLANEOUS PRODUCTS COMPLEMENT INHIBITORS See Table 2 for Applicable Medications
Effective Date: 2/1/2026	Review/Revised Date: 08/24, 09/24, 06/25, 08/25, 11/25 (KN)
Original Effective Date: 08/24	P&T Committee Meeting Date: 06/24, 08/24, 10/24, 06/25, 08/25, 10/25, 12/25
Approved by: Oregon Region Pharmacy and Therapeutics Committee	

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

APPLIES TO:

Commercial

- Note: Human Monoclonal Antibody (HmAb) Complement (C5) Inhibitors on this policy may be excluded from coverage for certain groups.

Medicaid

POLICY CRITERIA:

COVERED USES:

All Food and Drug Administration (FDA)-Approved Indications not otherwise excluded from the benefit.

REQUIRED MEDICAL INFORMATION:

For ALL REQUESTS:

1. Dose and frequency must be in accordance with FDA-approved labeling
2. The requested agent must not be given concurrently with another Complement Inhibitor (for example Ultomiris® or Empaveli®), or neonatal Fc receptor blocker (for example, Rystiggo®, Vyvgart®, Vyvgart Hytrulo®)

For Initial Authorization, the following indication-specific criteria must be met:

1. **For Paroxysmal Nocturnal Hemoglobinuria (PNH)**, Bkemv, Empaveli, Epysqli, Soliris, Fabhalta, Ultomiris, PiaSky, or Voydeya may be covered if the following criteria are met:
 - a. Documented, confirmed diagnosis of PNH by Flow Cytometric Immunophenotyping (FCMI) using at least two independent flow cytometry reagents on at least two cell lineages (such as red blood cells [RBCs] and white blood cells [WBCs]) demonstrating that the patient’s peripheral blood cells are deficient in glycosylphosphatidylinositol (GPI)-linked

**PHARMACY PRIOR AUTHORIZATION
POLICY AND CRITERIA
ORPTCOTH053**

**MISCELLANEOUS PRODUCTS
COMPLEMENT INHIBITORS**
See [Table 2](#) for Applicable Medications

proteins (which may include CD59, CD55, CD14, CD15, CD16, CD24, CD45, and CD64)

- b. Symptomatic hemolytic PNH defined as lactate dehydrogenase (LDH) levels greater than or equal to 1.5 times the upper limit of normal and at least one of the following prior to initiating therapy with a complement inhibitor:
 - i. Documented history of thrombosis
 - ii. Transfusion dependence (for example, hemoglobin less than 7 g/dL or symptomatic anemia with hemoglobin less than 9 g/dL)
 - iii. Disabling fatigue
 - iv. End-organ complications
 - v. Frequent pain paroxysms (for example, dysphagia or abdominal pain)
 - c. For Fabhalta, and PiaSky: Trial and failure, intolerance, or contraindication to ravulizumab-cwvz (Ultomiris) and pegcetacoplan (Empaveli). Pegcetacoplan may be waived for PiaSky requests in patients less than 18 years of age
 - d. For Soliris and Bkempv: Trial and failure, intolerance, or contraindication to ravulizumab-cwvz (Ultomiris), pegcetacoplan (Empaveli), and Epysqli (eculizumab-aagh)
 - e. For Voydeya, all the following criteria must be met:
 - i. Documentation of extravascular hemolysis while on ravulizumab or eculizumab
 - ii. Trial and failure, intolerance, or contraindication to pegcetacoplan (Empaveli) OR documentation of medical rationale for not switching to Empaveli therapy
 - iii. Documentation that danicopan (Voydeya) will be used concomitantly with ravulizumab or eculizumab
 - iv. For authorization of danicopan 200 mg dose, must meet one of the following:
 - 1) Documentation of a hemoglobin level that has not increased by greater than 2 g/dL after at least four weeks of initial therapy with 150 mg dose three times daily
 - 2) Patient required a transfusion during the previous four weeks
- 2. For Complement-Mediated Hemolytic Uremic Syndrome (HUS), Bkempv, Epysqli, Soliris or Ultomiris may be covered if the following criteria are met:**
- a. Diagnosis of non-infectious HUS, meaning HUS is not due to infection with Shiga toxin-producing Escherichia coli
 - b. Clinical presentation that includes: microangiopathic hemolytic anemia (hemoglobin less than 10 g/dL), thrombocytopenia (platelets less than

- 150), and acute kidney injury (elevations in serum creatinine) prior to initiating therapy with a complement inhibitor
- c. For Soliris® and Bkembv®: Trial and failure, intolerance, or contraindication to ravulizumab-cwvz (Ultomiris®) and Epysqli (eculizumab-aagh)
3. **For Neuromyelitis Optica Spectrum Disorder (NMOSD)**, Bkembv, Epysqli, Soliris or Ultomiris may be covered if the following criteria are met:
- a. Presence of at least one core clinical characteristic (optic neuritis, acute myelitis, area postrema syndrome, acute brainstem syndrome, symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions, symptomatic cerebral syndrome with NMOSD-typical brain lesions)
 - b. Anti-AQP4 antibody positive
 - c. Documentation that other alternative diagnoses have been excluded (such as multiple sclerosis)
 - d. Trial and failure, intolerance (such as neutropenia, LFT elevation, hypogammaglobulinemia) or contraindication to rituximab
 - e. For Ultomiris® and Epysqli®: Trial and failure, intolerance (such as neutropenia, LFT elevation, hypogammaglobulinemia), or contraindication to satralizumab (Enspryng®)
 - f. For Soliris® and Bkembv®: Trial and failure, intolerance (such as neutropenia, LFT elevation, hypogammaglobulinemia), or contraindication to both ravulizumab-cwvz (Ultomiris®), satralizumab (Enspryng®), and eculizumab-aagh (Epysqli®)
4. **For Generalized Myasthenia Gravis (gMG)**, Bkembv, Epysqli, Zilbrysq, Soliris or Ultomiris may be covered if the following criteria are met:
- a. Anti-acetylcholine receptor (anti-AChR) antibody positive
 - b. Myasthenia Gravis Foundation of America (MGFA) Clinical Classification Class II to IV
 - c. Myasthenia Gravis - Activities of Daily Living (MG-ADL) total score greater than five
 - d. Failed treatment for at least one year with ONE of the following:
 - i. At least TWO immunosuppressive therapies ([ISTs] such as azathioprine, mycophenolate mofetil, cyclosporine and tacrolimus, corticosteroids)
 - ii. ONE immunosuppressive therapy and at least four infusions/ year of either intravenous immunoglobulin (IVIg) OR plasma exchange (PE)
 - e. For Soliris® and Bkembv®: Trial and failure, intolerance, or contraindication to ravulizumab-cwvz (Ultomiris®) and eculizumab-aagh (Epysqli®)

5. **For Complement 3 Glomerulopathy (C3G)**, Fabhalta® and Empaveli® may be covered if the following criteria are met:
 - a. Diagnosis of C3G confirmed by renal biopsy
 - b. Patient has been receiving a maximally tolerated dose of an angiotensin-converting enzyme (ACE) inhibitor, angiotensin receptor blockers (ARB), or stable dose of other antiproteinuric medications including mycophenolic acid, corticosteroids and mineralocorticoid receptor antagonists for at least 90 days prior to initiating therapy
 - c. Urine protein-to-creatinine ratio UPCR of 1.0 g/g or more
 - d. eGFR greater than or equal to 30 mL/min^{1.73m²}
 - e. For Fabhalta®: Inadequate response, intolerance, or contraindication to pegcetacoplan (Empaveli®)

6. **For primary immunoglobulin A nephropathy (IgAN)**, Fabhalta® may be covered if all the following criteria are met:
 - a. Diagnosis of primary immunoglobulin A nephropathy (IgAN), confirmed by biopsy
 - b. Patient has been receiving a stable dose (for at least three months) of an angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB), at a maximally tolerated dose
 - c. Patient is at high risk of disease progression, defined as meeting one of the following criteria (i. or ii.)
 - i. Proteinuria of more than 1.0 g/day; **OR**
 - ii. Urine protein-to-creatinine ratio (UPCR) of 1.0 g/g or more
 - d. Patient has tried and failed, or has a contraindication to, BOTH sparsentan (Filspari®) AND budesonide delayed-release (Tarpeyo®)
 - e. Fabhalta® will not be used in combination with sparsentan (Filspari®) or budesonide delayed-release (Tarpeyo®)
 - f. eGFR greater than or equal to 25 mL/min/1.73 m²

For patients established on the requested medication within the previous year, must meet the indication-specific criteria below:

1. For **PNH**, reduced LDH levels, reduced transfusion requirements, increase or stabilization of hemoglobin levels, or improvement in symptoms
2. For **HUS**, improvement in at least two thrombotic microangiopathy endpoints, such as:
 - a. Maintenance of platelet counts (i.e., improvements or reductions less than 25%)
 - b. Reductions in LDH
 - c. Reduction in number of needed plasmapheresis or plasma infusion events
 - d. Improvement in kidney function
3. For **NMOSD**, positive clinical response as defined by a reduction in relapses

**PHARMACY PRIOR AUTHORIZATION
POLICY AND CRITERIA
ORPTCOTH053**

**MISCELLANEOUS PRODUCTS
COMPLEMENT INHIBITORS**
See [Table 2](#) for Applicable Medications

4. For **MG**: Documentation of sustained improvement in MG-ADL by at least two points from baseline
5. For **C3G and IgAN**, documentation of positive response to therapy defined as improvement in proteinuria

EXCLUSION CRITERIA: N/A

AGE RESTRICTIONS:

Age must be appropriate based on FDA-approved indication

PRESCRIBER RESTRICTIONS (For Commercial only):

- C3G, PNH or aHUS: Prescribed by a hematologist/oncologist or nephrologist
- MG or NMOSD: Prescribed by a neurologist
- IgAN: Prescribed by a nephrologist

COVERAGE DURATION:

Initial authorization for up to three months and reauthorization will be approved for up to one year.

QUANTITY LIMIT:

Empaveli: 160 mL per 28 days

Fabhalta: two capsules per day

Voydeya: six tablets per day

Requests for indications that were approved by the FDA within the previous six (6) months may not have been reviewed by the health plan for safety and effectiveness and inclusion on this policy document. These requests will be reviewed using the New Drug and or Indication Awaiting P&T Review; Prior Authorization Request ORPTCOPS047.

Requests for a non-FDA approved (off-label) indication requires the proposed indication be listed in either the American Hospital Formulary System (AHFS), Drugdex, or the National Comprehensive Cancer Network (NCCN) and is considered subject to evaluation of the prescriber's medical rationale, formulary alternatives, the available published evidence-based research and whether the proposed use is determined to be experimental/investigational.

Coverage for Medicaid is limited to a condition that has been designated a covered line item number by the Oregon Health Services Commission listed on the Prioritized List of Health Care Services.

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case.

INTRODUCTION:

The complement system is a system composed of over 50 proteins that is

**PHARMACY PRIOR AUTHORIZATION
POLICY AND CRITERIA
ORPTCOTH053**

**MISCELLANEOUS PRODUCTS
COMPLEMENT INHIBITORS**
See [Table 2](#) for Applicable Medications

involved in the innate immune response. When unregulated, this system may lead to numerous diseases including paroxysmal nocturnal hemoglobinuria (PNH). Several drugs have been developed to target the complement system ([see Table 1](#)) and treat PNH as well as atypical hemolytic uremic syndrome, myasthenia gravis, and neuromyelitis optica spectrum disorder²⁵.

FDA APPROVED INDICATIONS:

Table 1. Complement Inhibitors and their respective FDA-approved ages and indications

Drug	aHUS	gMG	NMOSD	PNH	C3G	IgAN
Bkemv (eculizumab-aeab)	X (age 2 months+)	X (age 18+)		X (age 18+)		
Empaveli (pegcetacoplan)				X (age 18+)	X (age 12+)	
Epysqli (eculizumab-aagh)	X (age 2 months+)	X (age 18+)		X (age 18+)		
Fabhalta (iptacopan)				X (age 18+)	X (age 18+)	X (age 18+)
PiaSky (crovalimab-akkz)				X (age 13+)		
Soliris (eculizumab)	X (age 2 months+)	X (age 6+)	X (age 18+)	X (age 18+)		
Ultomiris (ravulizumab-cwvz)	X (age 1 month+)	X (age 18+)	X (age 18+)	X (age 1 month+)		
Voydeya (danicopan)				X (age 18+)		
Zilbrysq (zilucoplan)		X (age 18+)				

Abbreviations: aHUS = Atypical Hemolytic Uremic Syndrome, C3G = Complement 3 Glomerulopathy, gMG = Generalized Myasthenia Gravis, HmAb = Humanized Monoclonal Antibody, IgAN = primary IgA nephropathy, NMOSD = Neuromyelitis Optica Spectrum Disorder, PNH = Paroxysmal Nocturnal Hemoglobinuria

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

POSITION STATEMENT:

Preferred use of biosimilar therapeutic immunomodulators

Biosimilars have been approved for use in the United States for several disease states that are currently treated with therapeutic immunomodulators. The United States Food and Drug Administration (FDA) defines a biosimilar as a “biological product that is highly similar to and had no clinically meaningful differences from an existing FDA-approved reference product.” The Companies have chosen to favor the use of biosimilar products to provide quality clinical care to our members in the most cost-effective manner.

Paroxysmal Nocturnal Hemoglobinuria (PNH)

Paroxysmal nocturnal hemoglobinuria (PNH) is a rare, acquired, life threatening disorder of the blood that develops from a mutation in the phosphatidylinositol glycan class A (PIGA) gene of hematopoietic stem cells and is characterized by destruction of red blood cells by the complement system. Intravascular hemolysis results in the release of free hemoglobin, causing toxic effects including hypercoagulability. C3 fragments not destroyed by the membrane attack complex may also accumulate on the surface of cells causing extravascular hemolysis. C5 inhibitors block the final step of the complement pathways while Factor B, D, and C3 inhibitors exert their actions further up in the pathway.

Clinical symptoms associated with PNH include headache, fever, abdominal and back, and fatigue. Hemolytic anemia, venous thrombosis, and other cytopenias related to bone marrow failure syndrome are considered in the differential diagnosis of PNH. Although allogeneic hematopoietic stem cell transplantation is considered a curative treatment, it is typically only used for patients with life-threatening disease due to the significant morbidity and mortality associated with it.¹⁹

Eculizumab is a monoclonal antibody approved for PNH which blocks the terminal complement pathway by binding to the C5 protein. When compared to placebo, eculizumab treatment resulted in improved survival and was well-tolerated.¹⁹

The FDA approval for ravulizumab (Ultomiris®) for use in the treatment of adult patients with paroxysmal nocturnal hemoglobinuria (PNH) was based on two phase 3 open-label non-inferiority clinical trials which provided a moderate quality of evidence that ravulizumab is as effective and safe as eculizumab for the treatment of PNH in adult patients that are treatment naïve and those stable on eculizumab. Additionally, ravulizumab has an advantage of a longer half-life than eculizumab.

The FDA approval for pegcetacoplan (Empaveli®) for use in the treatment of adult patients with PNH based on one phase 3, multicenter, randomized, head-to-head study (PEGASUS) comparing pegcetacoplan to eculizumab (Soliris®) in PNH patients stable on eculizumab for at least three months (N=80 adults).

Pegcetacoplan was found to be superior to eculizumab for the change from baseline in hemoglobin level at week 16 (adjusted mean change from baseline in hemoglobin was 2.37 g/dL with pegcetacoplan vs -1.47 g/dL with eculizumab [mean difference between treatments: 3.84 g/dL; 95% CI, 2.33-5.34; $p < 0.001$).

A 26-week, phase 3, multicenter, open-label, controlled study (PRINCE) studied pegcetacoplan in 53 complement inhibitor naïve adult patients. Participants had a hemoglobin level below the lower limit of normal and a LDH level ≥ 1.5 times the upper limit of normal. The coprimary endpoint was the avoidance of a greater than 1 g/dL decrease in hemoglobin from baseline and a change in baseline LDH levels. Hemoglobin stabilization occurred in 86% of the pegcetacoplan arm and 0% in the control arm and difference in change from baseline in LDH was -1470 (-2113.4, -827.3) $p < 0.0001$.⁶ Secondary endpoints included change from baseline hemoglobin 2.7 (0.99, 4.35) $p = 0.0019$ and transfusion avoidance 72% (56%, 89%) $p < 0.0001$.

Pegcetacoplan is only available through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) due to risk of serious infection. The recommended dose of pegcetacoplan is 1080 mg by subcutaneous infusion twice weekly through a commercially available infusion pump with a reservoir of at least 20mL.

- Usual infusion time is 60 minutes if using one infusion site and 30 minutes if using two infusion sites.

To reduce the risk of hemolysis associated with abrupt treatment discontinuation, the following are recommendations for switching to alternative products:

- If changing from eculizumab: pegcetacoplan should be started and eculizumab should be continued at its current dose. After four weeks of concomitant therapy, eculizumab can be discontinued.
- If changing from ravulizumab: pegcetacoplan should be started within four weeks of discontinuing treatment with ravulizumab.

Danicopan is effective as add-on therapy for patients experiencing extravascular hemolysis (EVH) on ravulizumab or eculizumab. It has not, however, demonstrated a net health benefit over pegcetacoplan alone. There are currently no biomarkers to identify whether switching to pegcetacoplan or utilizing add-on therapy is better for patients experiencing EVH.²³

Danicopan is currently part of a Risk Evaluation and Mitigation Strategies (REMS) program due to the risk of serious infections caused by encapsulated bacteria.

Hemolytic uremic syndrome (HUS)

Hemolytic uremic syndrome (HUS) is defined by hemolytic anemia, thrombocytopenia, and acute renal failure, in which the underlying lesions are mediated by systemic thrombotic microangiopathy (TMA). Atypical HUS (aHUS) is a sub-type of HUS, caused by decreased regulation of the alternative complement pathway on cell surfaces due to a genetic cause. After a diagnosis of a TMA, clinical diagnosis of aHUS requires thrombotic thrombocytopenic purpura (TTP) and Shiga toxin-producing *E. coli*-associated hemolytic uremic syndrome (STEC-HUS) to be ruled out. TTP is usually ruled out by an ADAMTS13 activity greater than 10%. aHUS is an extremely rare disease that, despite the administration of previous standard treatment with plasma therapy, often progresses to terminal chronic renal failure with a high associated rate of mortality. A Kidney Disease: Improving Global Outcomes (KDIGO) controversies conference recommend all patients with a clinical diagnosis of aHUS be eligible for treatment with a complement inhibitor. At this time there are no direct comparisons between ravulizumab and eculizumab in the treatment of aHUS. Obtaining genetic or molecular studies should not delay treatment as early treatment can avoid irreversible kidney damage. Discontinuation of plasma therapy or complement inhibition may be possible if some patients with aHUS.

Generalized Myasthenia Gravis (gMG)

Generalized Myasthenia gravis (gMG) is an autoimmune disorder of neuromuscular transmission. It is characterized by muscle weakness including ocular motor disturbances, oropharyngeal, respiratory, and limb muscle weakness. Symptoms can fluctuate and can become progressively severe. This disorder occurs when proteins in the postsynaptic membrane of the neuromuscular junction (acetylcholine receptors and/or receptor-associated proteins) are attacked by antibody-mediated T-cells. The diagnosis of myasthenia gravis can be established by clinical and serologic testing.

The myasthenia gravis activities of daily living (MG-ADL) is a categorical scale that assesses the impact on daily function of 8 signs or symptoms that are typically affected in gMG. Cumulative scores range from 0-24, with higher scores representing more severe disease. A 2-point decrease in the MG-ADL indicates clinical improvement. The MG-ADL correlates with the Quantitative Myasthenia Gravis (QMG) score, which is a 13-item direct physician assessment scoring system quantifying disease severity based on body function impairment. QMG cumulative scores range from 0-39, with higher scores representing more severe disease. A 2-3 point decrease in the QMG indicates clinical improvement.

Institute for Clinical and Economic Review conducted a systematic literature review and cost-effectiveness analysis to evaluate the health and economic outcomes of eculizumab for the treatment of myasthenia gravis. The report found that there is

moderate certainty eculizumab has a small net health benefit over conventional therapy, with the possibility of a substantial net benefit. The report concluded that eculizumab estimated cost effectiveness is well above usual thresholds for cost-effectiveness. Step therapy through efgartigimod was not encouraged at this time, but may be reasonable, as further evidence accumulates, based on price.

Ravulizumab (Ultomiris®), is a monoclonal antibody that inhibits terminal complement mediated intravascular hemolysis. It was engineered from eculizumab to have an extended half-life; its terminal half is approximately four times longer than that of eculizumab. Therefore, ravulizumab is dosed at a lower frequency than eculizumab. Ravulizumab is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS).

- Prescribers must enroll in the program. Enrollment in the Ultomiris REMS program and additional information are available at www.ultomirisrems.com.
- The ALXN1210-MG-306 study evaluated the safety and efficacy of ravulizumab compared to placebo in patients (n=89) with gMG positive for anti-AChR antibodies. Treatment with ravulizumab demonstrated a statistically significant improvement in the MG-ADL (-1.6, confidence interval [CI] -2.6 to -0.7, $p < 0.001$) and Quantitative Myasthenia Gravis (QMG) total scores (-2.0, CI -3.2 to -0.8, $p < 0.001$) from baseline at Week 26 as compared to placebo. Notably, the least squares mean of the MG-ADL score improvement did not reach a clinically significant decrease of 2 or more.

Zilucoplan (Zilbrysq®) is the first self-administered targeted C5 complement inhibitor for gMG that is administered once daily.

- Efficacy data is based on a phase 3 randomized control trial, RAISE.
- There is moderate quality of evidence that zilucoplan results in a statistically significant difference in the MG-ADL (Myasthenia Gravis-Specific Activities of Daily Living) responder rate compared to placebo in adults with generalized myasthenia gravis who are anti-acetylcholine receptor (AChR) antibody positive.
- At week 12, treatment with zilucoplan demonstrated a statistically significant improvement from baseline compared to placebo for MG-ADL total score.

Neuromyelitis Optica Spectrum Disorder (NMOSD)

Neuromyelitis Optica Spectrum Disorder (NMOSD), previously known as Devic disease or neuromyelitis optica (NMO), is an autoimmune inflammatory disorder of the central nervous system. It is primarily characterized by recurrent optic neuritis and myelitis often resulting in poor recovery. Aquaporin-4 (AQP4) is a water channel protein that astrocytes in the central nervous system express. Preclinical data indicate that AQP4-IgG triggers the complement cascade, which leads to inflammation and the formation of the membrane attack complex. The membrane attack complex leads to astrocyte destruction and neuronal injury but is not seen in

experimental models in the presence of a complement inhibitor. Diagnostic criteria for NMOSD require at least one core clinical characteristic (e.g., optic neuritis, acute myelitis, area postrema syndrome).¹³ AQP4 autoantibodies are detected in approximately 80% of patients with NMOSD.²⁴

Although off-label, azathioprine and mycophenolate mofetil have been utilized to effectively reduce NMOSD attacks for over 20 years in patients with both AQP4-IgG-positive and -negative patients. They are both considered inferior to rituximab.²⁴

There are four monoclonal antibody immunotherapies approved for patients with AQP4-IgG-positive NMOSD which have shown efficacy in the treatment of AQP4-IgG-positive NMOSD, eculizumab, inebilizumab, satralizumab, and ravulizumab. Their targets are as follows:

- Eculizumab: complement protein C5
- Inebilizumab: B cells through the CD19 antigen
- Ravulizumab: complement protein C5
- Satralizumab: Interleukin-6 (IL6)²⁴

Of note, the efficacy of rituximab in reducing NMOSD attacks by over 80% has been demonstrated by multiple studies over the last 15 years with one of the most recent studies resulting in its approval for NMOSD in Japan.²⁴

Due to the rarity of the condition, comparator trials would not be feasible as thousands of patients would need to be enrolled.²⁴

Primary Immunoglobulin A nephropathy (IgAN)

Primary IgAN impairs the kidney's ability to filter, causing blood and protein to leak into the urine. Patients will usually present with red-colored urine (hematuria), flank pain, swelling in the ankles, and high blood pressure. After living with IgAN for greater than or equal to 10 years, up to 40% of patients will develop end state renal disease (ESRD), requiring dialysis or renal transplant. Therefore, the goal in treating IgAN is to prevent or delay progression to ESRD.²⁶ IgAN is a rare disease but is the most common primary glomerular disease worldwide (incidence estimated at 2 to 10 per 100,000). IgAN can present at any age but is most commonly diagnosed in patients in their 20s and 30s. Diagnosis is made by a kidney biopsy and is usually performed once a patient has persistent proteinuria.^{26,27} Fabhalta® is an oral factor B inhibitor of the alternative complement pathway indicated to reduce proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression.¹

The Kidney Disease: Improving Global Outcomes (KDIGO) 2021 Clinical Practice Guidelines recommend initial therapy with an ACE inhibitor or ARB for patients with

**PHARMACY PRIOR AUTHORIZATION
POLICY AND CRITERIA
ORPTCOTH053**

**MISCELLANEOUS PRODUCTS
COMPLEMENT INHIBITORS**
See [Table 2](#) for Applicable Medications

proteinuria >0.5 g per day, regardless of whether or not the patient has hypertension. Clinical trials supporting the use of ACE inhibitors and ARBs are limited in IgAN, so their use is primarily based on their mechanism of slowing the rate of chronic kidney disease (CKD) progression. At least 50% of IgAN patients will not reach disease remission with an ACE inhibitor or ARB alone.²⁷ The 2024 draft update to the KDIGO guidelines recommends treatment of IgAN with optimized maximally tolerated ACE or ARB (1B), sparsentan (2B), budesonide extended-release (2B), or an SGLT2 inhibitor (2B).²⁸ Iptacopan has not yet been incorporated into the draft guideline update.

WARNING: SERIOUS MENINGOCOCCAL INFECTIONS

Life-threatening and fatal meningococcal infections have occurred in patients treated with Soliris® and Ultomiris®. Meningococcal infection may become rapidly life-threatening or fatal if not recognized and treated early.

- Comply with the most current Advisory Committee on Immunization Practices (ACIP) recommendations for meningococcal vaccination in patients with complement deficiencies.
- Immunize patients with a meningococcal vaccine at least two weeks prior to administering the first dose of Soliris/Ultomiris unless the risks of delaying Soliris therapy outweigh the risk of developing a meningococcal infection.
- Monitor patients for early signs of meningococcal infections and evaluate immediately if infection is suspected.

Soliris/Ultomiris is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS).

TABLE 2: BILLING GUIDELINES AND CODING:

HCPCS	Coding Description	Brand Name
Medical Benefit		
J7799, C9399	Unclassified drugs or biologicals	Empaveli
J1307	Injection, crovalimab-akkz, 10 mg	PiaSky
J1299	Injection, eculizumab, 2 mg	Soliris
Q5151	Injection, eculizumab-aagh (epysqli), biosimilar, 2 mg	Epysqli
Q5152	Injection, eculizumab-aeeb (bkemv), biosimilar, 2 mg	Bkemv
J1303	Injection, ravulizumab-cwvz, 10 mg	Ultomiris
J3490, C9399	Unclassified drugs or biologicals	Zilbrysq
Pharmacy Benefit		
J8499	Prescription drug, oral, non chemotherapeutic, nos	Fabhalta

**PHARMACY PRIOR AUTHORIZATION
POLICY AND CRITERIA
ORPTCOTH053**

**MISCELLANEOUS PRODUCTS
COMPLEMENT INHIBITORS**
See [Table 2](#) for Applicable Medications

J8499	Prescription drug, oral, non chemotherapeutic, nos	Voydeya
ADMINISTRATION CODES ◇		
96365	Ther/proph/diag iv inf init	
96366	Ther/proph/diag iv inf addon	
96369	Sc ther infusion up to 1 hr	
96371	Sc ther infusion reset pump	
96372	Ther/proph/diag inj sc/im	
96401	Chemo anti-neopl sq/im	
96413	Chemo iv infusion 1 hr	
96415	Chemo iv infusion addl hr	

◇ Coding/Administration Notes:

- The above code list is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit.
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as “medically unlikely edits” (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCE/RESOURCES:

1. Relevant package inserts.
2. Brodsky RA. Paroxysmal nocturnal hemoglobinuria. *Blood*. 2014;124(18):2804-2811.
3. Parker C, Omine M, Richards S, et al. Diagnosis and management of paroxysmal nocturnal hemoglobinuria. *Blood*. 2005;106(12):3699-709.
4. Pitttock SJ, Berthele A, Fujihara K et al. Eculizumab in Aquaporin-4–Positive Neuromyelitis Optica Spectrum Disorder. *N. Engl. J. Med.* 2019; 381:614-625.
5. Rathbone J, Kaltenthaler E, Richards A, et al. A systematic review of eculizumab for atypical haemolytic uraemic syndrome (aHUS). *BMJ Open*. 2013;3(11):e003573.
6. Kim SH, Huh SY, Lee SJ, et al. A 5-year follow-up of rituximab treatment in patients with neuromyelitis optica spectrum disorder. *JAMA Neurol*. 2013 Sep 1;70(9):1110-7.
7. Gao F, Bingyan C, Gu C et al. Effectiveness of rituximab in neuromyelitis optica: a meta-analysis. *BMC Neurology*. 2019; 19:36/
8. Sellner J, Boggild M, Clanet M et al. EFNS guidelines on diagnosis and management of neuromyelitis optica. *European Journal of Neurology*. 2010; 17:1019-1032.
9. Stellmann JP, Krumbholz M, Friede T et al. Immunotherapies in neuromyelitis optica spectrum disorder: efficacy and predictors of response. *J Neurol Neurosurg Psychiatry*. 2017; 88(8): 639-647.

**PHARMACY PRIOR AUTHORIZATION
POLICY AND CRITERIA
ORPTCOTH053**

**MISCELLANEOUS PRODUCTS
COMPLEMENT INHIBITORS**
See [Table 2](#) for Applicable Medications

10. Trebst C, Jarius S, Berthele A et al. Update on the diagnosis and treatment of neuromyelitis optica: recommendations of the Neuromyelitis Optica Study Group (NEMOS). *J Neurol*. 2014; 261(1): 1-16.
11. Scott TF, Frohman EM, De Seze J. Evidence-based guideline: Clinical evaluation and treatment of transverse myelitis: Report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology. *Neurology* 2011; 77: 2128-34.
12. Mealy MA, Wingerchuk DM, Palace J, et al. Comparison of Relapse and Treatment Failure Rates Among Patients With Neuromyelitis Optica: Multicenter Study of Treatment Efficacy. *JAMA Neurol*. 2014 Jan 20.
13. Wingerchuk DM, Banwell B, Bennet JL et al. International consensus diagnostic criteria for neuromyelitis optica spectrum disorders. *Neurology*. 2015;85(2).
14. Goodship T, Cook HT, Fakhouri F, et al. Atypical hemolytic uremic syndrome and C3 glomerulopathy: conclusions from a “Kidney Disease: Improving Global Outcomes” (KDIGO) Controversies Conference. *Kidney International*. 2017; 91(3): 539-551.
15. National Organization for Rare Disorders (NORD). Atypical hemolytic uremic syndrome. Available from: <https://rarediseases.org/rare-diseases/atypical-hemolytic-uremic-syndrome/>. Accessed May 4, 2021.
16. Eculizumab and efgartigimod for the treatment of myasthenia gravis: Effectiveness and value. Institute for Clinical and Economic review. October 2021. Available from: https://icer.org/wp-content/uploads/2021/03/ICER_Myasthenia-Gravis_Final-Report_102021-1.pdf
17. Lee JW, Fontbrune S, Lee WL, et al. Ravulizumab (ALXN1210) vs eculizumab in adult patients with PNH naïve to complement inhibitors: the 301 study. *Blood*. 2018.
18. Kulasekararaj AG, Hill A, Rottinghaus ST, et al. Ravulizumab (ALXN1210) vs eculizumab in C5-inhibitor-experienced adult patients with PNH: the 302 study. *Blood*. 2018.
19. Cançado RD, Araújo ADS, Sandes AF, et al. Consensus statement for diagnosis and treatment of paroxysmal nocturnal haemoglobinuria. *Hematol Transfus Cell Ther*. 2021 Jul-Sep;43(3):341-348.
20. Sahin F, Akay OM, Ayer M, Dal MS, Ertop S, Ilhan O, Karakus V, Ozcan MA, Ozkocaman V, Ozsan H, Salim O, Tobu M, Tombak A, Tuglular TF, Yilmaz M, Unal A, Yenerel MN, Saydam G. PNH diagnosis, follow-up and treatment guidelines. *Am J Blood Res*. 2016 Aug 5;6(2):19-27.
21. Wong RSM, Navarro-Cabrera JR, Comia NS, et al. Pegcetacoplan controls hemolysis in complement inhibitor-naïve patients with paroxysmal nocturnal hemoglobinuria. *Blood Adv*. 2023 Jun 13;7(11):2468-2478.
22. Howard JF, Bresch S, Genge A. Safety and efficacy of zilucoplan in patients

**PHARMACY PRIOR AUTHORIZATION
POLICY AND CRITERIA
ORPTCOTH053**

**MISCELLANEOUS PRODUCTS
COMPLEMENT INHIBITORS**
See [Table 2](#) for Applicable Medications

- with generalized myasthenia gravis (RAISE): a randomized, double-blind, placebo-controlled, phase 3 study. *Lancet*. 2023; 22(5): 395-406.
23. Iptacopan and Danicopan for Paroxysmal Nocturnal Hemoglobinuria: Final Evidence Report. Institute for Clinical and Economic Review March 13, 2024. https://icer.org/wp-content/uploads/2024/03/PNH_Final-Report_For-Publication_03132024.pdf.
 24. Kumpfel T, Gighuber K, Aktas O. Update on the diagnosis and treatment of neuromyelitis optica spectrum disorders (NMOSD) – revised recommendations of the Neuromyelitis Optica Study Group (NEMOS). Part II: Attack therapy and long-term management. *J Neuro* 2024; 271:141-176.
 25. Gavriilaki E, Peffault de Latour R, Risitano AM. Advancing therapeutic complement inhibition in hematologic diseases: PNH and beyond. *Blood* 2022;139(25):3571-3582.
 26. Filspari (sparsentan) tablet Prime Therapeutics Monograph. Updated on March 1, 2023.
 27. Rovin BH, Barratt J, Heerspink HJL, et al. Efficacy and safety of sparsentan versus irbesartan in patients with IgA nephropathy (PROTECT): 2-year results from a randomised, active-controlled, phase 3 trial. *Lancet*. 2023;402(10417):2077-2090.
 28. Kidney Diseases: Improving Global Outcomes (KDIGO) 2024 clinical practice guidelines for the management of immunoglobulin A nephropathy (IgAN) and immunoglobulin A vasculitis (IgAV). Draft published online ahead of print. Available at: <https://kdigo.org/igan-igav-public-review-draft/>. Accessed on Aug 19, 2025