Policy and Procedure	
PHARMACY PRIOR AUTHORIZATION POLICY AND CRITERIA ORPTCOTH051.1225	**MISCELLANEOUS PRODUCTS** **MEDICATIONS FOR RARE INDICATIONS** See Table 2 for Applicable Medications
Effective Date: 1/1/2026	**Review/Revised Date**: 08/24, 09/24, 12/24, 04/25, 08/25, 10/25, 12/25 (KN)
Original Effective Date: 02/24	**P&T Committee Meeting Date**: 12/23, 08/24, 12/24, 04/25, 10/25, 12/25
Approved by: Oregon Region Pharmacy and Therapeutics Committee	

SCOPE:
Providence Health Plan and Providence Health Assurance as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:
Medicare Part B

POLICY CRITERIA:

COVERED USES:
All Food and Drug Administration (FDA) approved indications not otherwise excluded from the benefit.

REQUIRED MEDICAL INFORMATION:

INITIAL AUTHORIZATION CRITERIA: both of the following must be met:
1. Confirmation of FDA-labeled indication (appropriate lab values and/or genetic tests must be submitted – [See Table 1])
2. Dosing is within FDA-labeled guidelines OR documentation has been submitted in support of therapy with a higher dose for the intended diagnosis such as high-quality peer reviewed literature, guidelines, other clinical information

REAUTHORIZATION CRITERIA: all the following must be met:
1. Documentation of successful response to therapy
2. Dosing is within FDA-labeled guidelines OR documentation has been submitted in support of therapy with a higher dose for the intended diagnosis such as high-quality peer reviewed literature, guidelines, other clinical information
3. For Nulibry®: Genetic testing to confirm mutation in the *MOCS1* gene (Nulibry® should be discontinued if the MoCD Type A diagnosis is not confirmed by genetic testing)
4. For Qalsody®: Stabilization or slowing of disease progression from pre-treatment baseline ALSFRS-R scores
5. For Spevigo® IV:
    a. All criteria for initial authorization must be met AND

   b. Documentation of a clinical response to prior treatment with spesolimab, defined as achieving a Generalized Pustular Psoriasis Physician Global Assessment (GPPGA) score of 0 or 1

6. For Vyjuvek®:
   a. Documentation of successful response to therapy as indicated by complete wound healing or decrease in wound size
   b. Patient continues to have incomplete wound closures that are clean in appearance with adequate granulation tissue, excellent vascularization, and do not appear infected

EXCLUSION CRITERIA: N/A
For Vyjuvek®:
1. Skin graft within the past three months
2. Current evidence or a history of squamous cell carcinoma in the area(s) that will undergo treatment
3. Combination therapy with Vyjuvek and Filsuvez

For Zevaskyn®: Combination therapy with Vyjuvek and Filsuvez

AGE RESTRICTIONS:
Age must be appropriate based on FDA-approved indication

PRESCRIBER RESTRICTIONS:
Must be prescribed by, or in consultation with a specialist in the respective disease state.

COVERAGE DURATION:
- For Nulibry®: Initial authorization will be approved for three months. Reauthorization will be approved for 12 months.
- For Ryplazim®: Initial and reauthorization will be approved for 6 months.
- For Enjaymo®, Qalsody®, and Vyjuvek®: Initial authorization will be approved for six months. Reauthorization will be approved for 12 months.
- For Skysona® and Zevaskyn®: Authorization is limited to one treatment course per lifetime. Approval duration will be for 12 weeks.
- For Spevigo® IV: Initial authorization and reauthorization will be approved for two weeks, limited to one 900 mg (2 vials) infusion.
- For all other medications: Initial authorization will be approved for one year and reauthorization will be approved until no longer eligible with the plan, subject to formulary or benefit changes.

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 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:

In the United States, Congress defines a rare disease as one that affects fewer than 200,000 people[5]. Congress recognized that people with rare diseases often did not have many treatment options, so it created the Orphan Drug Act (ODA) of 1983 to incentivize drug developers to create medications for these populations[4]. Since then, a significant number of drugs have emerged on the market for use in rare indication with more to come. On June 29, 2017, The Food and Drug Administration (FDA) unveiled a strategic plan to reduce its backlog of orphan drug requests to expedite the process.[6]

POSITION STATEMENT:

The purpose of this policy is to ensure safe and effective therapy for patients with rare diseases. A list of rare diseases can be found at National Institute of Health (NIH) website[2] and a list of orphan drugs can be found at the FDA website[3].

Table 1. FDA Indication(s)[1] and Initial Authorization Criteria

Drug	FDA Indication(s)	
Enjaymo® (sutimlimab-jome injection)	Treatment of hemolysis in adults with cold agglutinin disease (CAD)	• Diagnosis of primary cold agglutinin disease (CAD) by all the following: ○ Chronic hemolysis, confirmed by low levels of haptoglobin, and high levels of unconjugated bilirubin and lactate dehydrogenase ○ Positive direct antiglobulin (Coombs) test for C3d. (Note: a positive is graded as a 1+, 2+, or 3+) ○ Cold agglutinin titer of 1:64 or higher at 4 degrees Celsius ○ Presence of one or more symptom associated with CAD such as symptomatic anemia, acrocyanosis, Raynaud's phenomenon, hemoglobinuria

Drug	FDA Indication(s)	
Gamifant® (emapalumab-lzsg vial)	Treatment of adult and pediatric (newborn and older) patients with primary hemophagocytic lymphohistiocytosis (HLH) with refractory, recurrent or progressive disease or intolerance with conventional HLH therapy. Treatment of adult and pediatric (newborn and older) patients with HLH/macrophage activation syndrome (MAS) in known or suspected Still's disease, including	For Primary HLH: Diagnosis of primary HLH based on a molecular diagnosis OR family history consistent with primary HLH OR 5 out of the following 8 criteria fulfilled:[7] 1. Fever 2. Splenomegaly 3. Cytopenias affecting 2 of 3 lineages in the peripheral blood: hemoglobin less than 9 g/dL, platelets less than 100 x 109/L, neutrophils less than 1 x 109/L 4. Hypertriglyceridemia (fasting triglycerides greater than 3 mmol/L or equal or greater than 265 mg/dL) and/or hypofibrinogenemia (equal or less than 1.5 g/L) 5. Hemophagocytosis in bone marrow, spleen, or lymph nodes with no evidence of malignancy 6. Low or absent NK-cell activity 7. Ferritin equal or greater than 500 mcg/L 8. Soluble CD 25 equal or greater than 2400 U/mL
Nulibry® (fosdenopterin vial)	To reduce the risk of mortality in patients with molybdenum cofactor deficiency (MoCD) Type A.	• Diagnosis of molybdenum cofactor deficiency (MoCD) Type A confirmed by a mutation in the *MOCS1* gene OR suspected molybdenum cofactor deficiency (MoCD) Type A
Qalsody® (tofersen)	Treatment of Amyotrophic lateral sclerosis (ALS) in adults who have a mutation in the superoxide dismutase 1 (SOD1) gene • This indication is approved under accelerated approval based on reduction in plasma neurofilament light chain (NfL) observed in patients treated with Qalsody. Continued approval for this indication may be contingent upon verification of clinical benefit in confirmatory trial(s).	• Diagnosis of amyotrophic lateral sclerosis (ALS) with mutation in the superoxide dismutase 1 (SOD1) gene • Patient has all of the following: o Documentation of baseline ALS Functional Rating Scale-Revised (ALSFRS-R) o Forced vital capacity (FVC) greater than or equal to 50% of predicted (taken within the past three months) • Documentation of weakness attributable to ALS
Ryplazim® (plasminogen, human-tvmh vial)	• Treatment of patients with plasminogen deficiency type 1 (hypoplasminogenemia)	1. Diagnosis of plasminogen deficiency type 1 confirmed by one of the following: A. Genetic testing (biallelic pathogenic variants in PLG gene)

Drug	FDA Indication(s)	
		B. Confirmed hypoplasminogenemia (reduced plasminogen protein levels and functional activity) 2. Documentation of plasminogen activity level of 45% or lower of laboratory standard within the previous six months • Documentation of clinical signs and symptoms of the disease (such as ligneous conjunctivitis, gingivitis, tonsillitis, abnormal wound healing)
Skysona® (elivaldogene)	• To slow the progression of neurologic dysfunction in boys 4-17 years of age with early, active cerebral adrenoleukodystrophy (CALD). Early, active cerebral adrenoleukodystrophy refers to asymptomatic or mildly symptomatic (neurologic function score, NFS ≤ 1) boys who have gadolinium enhancement on brain magnetic resonance imaging (MRI) and Loes scores of 0.5-9. • This indication is approved under accelerated approval based on 24-month Major Functional Disability (MFD)-free survival. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s). Limitations of Use • SKYSONA does not prevent the development of or treat adrenal insufficiency due to adrenoleukodystrophy. • An immune response to SKYSONA may limit the persistence of descendent cells of SKYSONA, causing rapid loss of efficacy of SKYSONA in patients with full deletions of the human adenosine triphosphate binding cassette, sub family D, member 1 (*ABCD1)* gene. • SKYSONA has not been studied in patients with CALD secondary to head trauma. • Given the risk of hematologic malignancy with SKYSONA, and	• Confirmed Adenosine Triphosphate (ATP)-binding cassette, subfamily D, member 1 (ABCD1) mutation • Patient has early active cerebral adrenoleukodystrophy (CALD) defined by ALL of the following: ○ Elevated very-long-chain fatty acid (VLCFA) values ○ Active central nervous system (CNS) disease established by central radiographic review of brain magnetic resonance imaging (MRI) demonstrating: ▪ Loes score between 0.5 and 9 (inclusive) on the 34-point scale ▪ Gadolinium enhancement on MRI of demyelinating lesions ○ Neurologic Function Score (NFS) of 1 or less • Documentation is provided indicating that patient has NONE of the following: ○ History of hematopoietic stem cell transplant (HSCT) ○ History of elivaldogene autotemcel treatment ○ HLA-matched willing sibling donor

Drug	FDA Indication(s)	
	unclear long-term durability of SKYSONA and human adrenoleukodystrophy protein (ALDP) expression, careful consideration should be given to the appropriateness and timing of treatment for each boy, especially for boys with isolated pyramidal tract disease based on available treatment options since their clinical symptoms do not usually occur until adulthood.	
Spevigo® IV (spesolimab)	Treatment of generalized pustular psoriasis (GPP) in adults and pediatric patients 12 years of age and older and weighing at least 40 kg	• Diagnosis of generalized pustular psoriasis (GPP), confirmed by both of the following: o Primary, sterile, macroscopically visible pustules on non-acral skin AND o Pustulation is not restricted to psoriatic plaques • Presence of an acute flare of generalized pustular psoriasis of moderate to severe intensity, as defined by: o Generalized Pustular Psoriasis Physician Global Assessment (GPPGA) total score of 3 or greater AND o The presence of new or worsening pustules AND o Generalized Pustular Psoriasis Physician Global Assessment (GPPGA) pustulation sub score of 2 or greater AND o At least 5% of body surface area (BSA) with erythema and the presence of pustules • Requests for one additional dose may be approved one week after initial dose for treatment of the same flare if the following criteria are met: o Generalized Pustular Psoriasis Physician Global Assessment (GPPGA) total score of 2 or higher AND Generalized Pustular Psoriasis Physician Global Assessment (GPPGA) pustulation sub score of 2 or higher

Drug	FDA Indication(s)	
Veopoz® (pozelimab-bbfg vial)	Adult and pediatric patients one year of age and older with CD55-deficient protein-losing enteropathy (PLE), also known as CHAPLE disease.	Confirmation of CD55 loss-of-function mutation detected by genetic testing
Vyjuvek® (beremagene geperpavec)	Treatment of wounds in adult and pediatric patients with dystrophic epidermolysis bullosa (DEB) with mutation(s) in the *collagen type VII alpha 1 chain (COL7A1)* gene	• Confirmed mutation in the collagen type VII alpha 1 chain (COL7A1) gene • Treatment will be used on a cutaneous wound (or wounds) that are clean in appearance with adequate granulation tissue, excellent vascularization, and do not appear infected
Zevaskyn® (prademagene zamikeracel)	Treatment of wounds in adult and pediatric patients with recessive dystrophic epidermolysis bullosa (RDEB)	• Genetic confirmation of mutations in both COL7A1 genes • Treatment will be used on partial-thickness RDEB wounds open chronically for at least six months

REFERENCE/RESOURCES:

1. Current package insert for each listed drug
2. National Institute of Health. Genetic and Rare Diseased Information Center (GARD). Accessed September 5, 2025. Available from https://rarediseases.info.nih.gov/
3. Food and Drug Administration. Search Orphan Drug Designations and Approvals. https://www.accessdata.fda.gov/scripts/opdlisting/oopd/index.cfm (accessed September 5, 2025).
4. Orphan Drugs, 21 C.F.R § 316 (1992)
5. U.S. Food and Drug Administration. Center for Drug Evaluation and Research. Rare Disease at FDA (2020). Accessed September 5, 2025. Available from https://www.fda.gov/patients/rare-diseases-fda
6. U.S. Food and Drug Administration. Center for Drug Evaluation and Research. Orphan Drug Modernization Plan (2018). Accessed September 5, 2025Available from https://www.fda.gov/industry/designating-orphan-product-drugs-and-biological-products/orphan-drug-modernization-plan
7. Rosee PL, Horne A, Hines M, et al. Recommendations for the management of meophagocytic lymphohistiocytosis in adults. *Blood*. 2019: 133(23):2465-2477. Available at: Recommendations for the management of hemophagocytic lymphohistiocytosis in adults | Blood | American Society of Hematology (ashpublications.org).
8. Jäger U, Barcellini W, Broome CM, et al. Diagnosis and treatment of autoimmune hemolytic anemia in adults: Recommendations from the First International Consensus Meeting. Blood Rev. 2020 May;41:100648

Table 2. BILLING GUIDELINES AND CODING:

DRUG CODES*		
HCPCS	**Coding Description**	**Brand Name**
J1302	Injection, sutimlimab-jome, 10 mg	Enjaymo®
J1304	Injection, tofersen, 1 mg	Qalsody®
J1747†	Injection, spesolimab-sbzo, 1 mg	Spevigo® IV
J1809	Injection, fosdenopterin, 0.1 mg	Nulibry®
J3590, C9399	Unclassified drugs or biologics	Kebilidi®
J3590, C9399	Unclassified drugs or biologics	Skysona®
J9210	Injection, emapalumab-lzsg, 1 mg	Gamifant®
J2998, C9090	Injection, plasminogen, human-tvmh, 1 mg	Ryplazim®
J9376	Injection, pozelimab-bbfg, 1 mg	Veopoz®
J3401	Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10^9 pfu/ml vector genomes, per 0.1 ml	Vyjuvek®
J3590, C9399	Unclassified drugs or biologics	Zevaskyn®
ADMINISTRATION CODES		
96365	Ther/proph/diag iv inf init	
96366	Ther/proph/diag iv inf addon	
96372	Ther/proph/diag inj sc/im	
96374	Ther/proph/diag inj iv push	
96401	Chemo anti-neopl sq/im	
96409	Chemo iv push sngl drug	
96413	Chemo iv infusion 1 hr	
93415	Chemo iv infusion addl hr	
62322	Njx interlaminar lmbr/sac	(Qalsody)
62323	Njx interlaminar lmbr/sac	(Qalsody)
15040	Harvest cultured skin graft	(Zevaskyn)
MODIFIER CODES†		
-JA	Administered Intravenously	
-JB	Administered Subcutaneously	
-JW	Drug Amount Discarded/Not Administered to Any Patient	
-JZ	Zero drug amount discarded/Not administered to Any Patient	

*Coding 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.

†Must be billed with the JA modifier for the intravenous infusion of the drug or billed with the JB modifier for the subcutaneous injection form of administration Discarded Drugs and Biologicals – JW Modifier and JZ Modifier Policy FAQ