EVH Clinical Guideline 5053.CC for Eculizumab & Ravulizumab Products

Guideline Number: EVH_CG_5053.CC	**Applicable Codes**	
"Evolent" refers to Evolent Health LLC and Evolent Specialty Services, Inc. 		
Original Date: March 2022	**Last Revised Date:** March 2025	**Implementation Date:** August 2025

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STATEMENT

General Information

- *It is the policy of the Health Plan to maintain a prior authorization process that promotes appropriate utilization of specific drugs with potential for misuse or limited indications. This process involves a review using Food and Drug Administration (FDA) criteria to make a determination of Medical Necessity, and approval by the Medical Policy Committee.*

- *If the established criteria are not met, the request is referred to a Medical Director for review, if required for the plan and level of request.*

Purpose

The purpose of this guideline to define the prior authorization process for the following drug(s): Bkemv™, Epysqli™, Soliris®, and Ultomiris®

Scope

This guideline applies to all practitioners who are involved in providing the requested drug. This guideline is specific to the Health Plan's medical benefit.

Special Note

Requests for eculizumab and ravulizumab products are subject to the preferred medical drug list program. This program applies to the products specified in this guideline and only to indications that are FDA-approved for the preferred product (as applicable). Coverage for non-preferred products is provided based on clinical circumstances that would exclude the use of the preferred product and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made.

Preferred Product Table	
Preferred	Ultomiris® (ravulizumab-cwvz)
Non-Preferred	Bkemv™ (eculizumab-aeeb) Epysqli™ (eculizumab-aagh) Soliris® (eculizumab)

INITIAL REVIEW CRITERIA

The request must meet all of the criteria listed under the General Criteria ***and*** diagnosis-specific sections below.

General Criteria

- Prescriber must be enrolled in the product's specific Risk Evaluation and Management Strategy program (e.g., Ultomiris and Soliris REMS, Bkemv REMS)
- Must be prescribed at a dose within the manufacturer's dosing guidelines (based on diagnosis, weight, etc.) listed in the FDA approved labeling
- Must be prescribed by or in consultation with a hematologist, oncologist, neurologist, immunologist, or genetic specialist
- Must not be used in combination with other biologic therapies used for the given diagnosis

Atypical Hemolytic Uremic Syndrome (aHUS)

- Must be the following age, depending on drug requested:
  - At least 1 month of age or older (Ultomiris)
  - At least 2 months of age or older (eculizumab products)
- Must have documentation or attestation from the provider of the following:
  - Thrombotic Thrombocytopenic Purpura (TTP) has been ruled out by evaluating ADAMTS-13 level (i.e., ADAMTS-13 activity level ≥ 10%)
  - Shiga toxin E. coli related to hemolytic uremic syndrome (STEC-HUS) has been ruled out
- Must provide documentation baseline serum LDH, platelet count, serum creatinine, and plasma exchange requirements
- **For non-preferred products:** Must have a trial and failure, intolerance, or contraindication to the preferred product

Myasthenia Gravis (MG)

- Must have a diagnosis of generalized myasthenia gravis, with documentation of a positive test for anti-acetylcholine receptor (AChR) antibody
  - For Soliris: Must be age 6 years or older
  - For all other products: Must be age 18 years or older
- Must have a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of class II to IV
- Must have a Myasthenia Gravis-Specific Activities of Daily Living (MG-ADL) total score of ≥ 6

- Must have a trial and failure, contraindication, or intolerance to at least ONE corticosteroid (e.g., prednisone)
- Must have a trial and failure or contraindication to at least ONE of the following (or intolerance of all):
  - At least TWO non-steroidal immunosuppressive therapies (e.g., azathioprine, cyclophosphamide, methotrexate)
  - At least ONE non-steroidal immunosuppressive therapy while on chronic plasmapheresis or plasma exchange
- **For non-preferred products:** Must have a trial and failure, intolerance, or contraindication to the preferred product

Neuromyelitis Optica Spectrum Disorder (NMOSD)

- Must have a diagnosis of neuromyelitis optica spectrum disorder (NMOSD)
- Must have documentation of a positive blood serum test for anti-aquaporin-4 antibodies (AQP4-IgG)
- Must be age 18 years or older
- Must have a history of ONE of the following:
  - At least 2 relapses in last 12 months
  - At least 3 relapses in the last 24 months, with at least 1 relapse in the 12 months prior to request
- Must have a baseline Expanded Disability Status Scale (EDSS) score of ≤ 7 (consistent with the presence of at least limited ambulation with aid)
- **For non-preferred products:** Must have a trial and failure, intolerance, or contraindication to the preferred product

Paroxysmal Nocturnal Hemoglobinuria (PHN)

- Must be the following age, depending on drug requested:
  - At least 1 month of age or older (Ultomiris)
  - At least 18 years of age or older (eculizumab products)
- Must have a laboratory confirmed diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) as evidenced by having detectable GPI-deficient hematopoietic clones (Type III PNH RBC) via Flow Cytometry. Documentation of Flow Cytometry pathology report support must indicate presence of PNH-type RBC (red blood cell) and must be submitted.
- Must have an LDH level 1.5 times the upper limit of the normal range (laboratory result with reference range must be submitted) and at least ONE sign or symptom of disease, such as:
  - Thromboembolic events
  - Symptomatic anemia

- Organ damage secondary to chronic hemolysis (e.g., renal insufficiency, pulmonary insufficiency)
- Abdominal pain
- Fatigue
- Erectile Dysfunction
- *EXCEPTION:* Members who are pregnant do not require a sign/symptom so long as provider deems potential benefit outweighs potential fetal risk

- Must have documentation of the following baseline laboratory values or information:
  - Hemoglobin level
  - Current RBC transfusion requirements
  - History of thrombotic events
- **For non-preferred products:** Must have a trial and failure, intolerance, or contraindication to the preferred product

REAUTHORIZATION CRITERIA

All prior authorization renewals are reviewed on an annual basis to determine the Medical Necessity for continuation of therapy. The request must meet all of the criteria listed under the diagnosis-specific sections below.

Atypical Hemolytic Uremic Syndrome (aHUS)

- Must have chart note documentation from prescriber showing that the member's condition has improved, as evidence by at least ONE of the following:
  - Decrease in serum LDH
  - Improvement in serum creatinine
  - Normalization of platelet counts
  - Decrease in plasma exchange
- Must be prescribed at a dose within the manufacturer's dosing guidelines (based on diagnosis, weight, etc.) listed in the FDA approved labeling
- Must not be used in combination with other biologic therapies used for aHUS

Myasthenia Gravis (MG)

- Must have a reduction in MG-ADL assessment score from pretreatment baseline
  - For subsequent reauthorizations, stability in the score may be accepted after initial improvement
- Must be prescribed at a dose within the manufacturer's dosing guidelines (based on diagnosis, weight, etc.) listed in the FDA approved labeling

- Must not be used in combination with other biologic therapies used for myasthenia gravis

Neuromyelitis Optica Spectrum Disorder (NMOSD)

- Must have chart note documentation from prescriber that member's condition has improved as evidenced by at least ONE of the following:
  - Decrease in frequency of relapse
  - Reduction in EDSS score from baseline
  - Reduced hospitalizations
- Must be prescribed at a dose within the manufacturer's dosing guidelines (based on diagnosis, weight, etc.) listed in the FDA approved labeling
- Must not be used in combination with other biologic therapies used for NMOSD

Paroxysmal Nocturnal Hemoglobinuria (PHN)

- Must have chart note documentation from the prescriber that member's condition has improved, as evidenced by one of the following: decrease in serum LDH, Hgb level above baseline, or reduction in need for blood transfusions
- Must be prescribed at a dose within the manufacturer's dosing guidelines (based on diagnosis, weight, etc.) listed in the FDA approved labeling
- Must not be used in combination with other biologic therapies used for PHN

APPROVAL DURATIONS

If the above criteria are met, the request will be approved for up to the duration of time dictated below:

Initial Authorization	Up to 1 year
Reauthorization	Up to 1 year

CODING AND STANDARDS

Codes

Code	Brand	Description
J1299	Soliris	Injection, eculizumab, 2mg
J1303	Ultomiris	Injection, ravulizumab-cwvz 10mg

Code	Brand	Description
J3590	Epysqli	Eculizumab-aagh
Q5139	Bkemv	Injection, eculizumab-aeeb (bkemv), biosimilar, 10mg

Applicable Lines of Business

☐	CHIP (Children's Health Insurance Program)
☐	Commercial
☐	Exchange/Marketplace
☒	Medicaid
☐	Medicare Advantage

BACKGROUND

Definitions

ADAMTS13 – A Disintegrin And Metalloprotease with a ThromboSpondin type 1 motif, member 13. A deficiency in ADAMTS13 protease can lead to Thrombotic Thrombocytopenic Purpura (TTP).

Myasthenia Gravis Foundation of America (MGFA) Disease Clinical Classification

Class I	Any ocular muscle weakness; may have weakness of eye closure. All other muscle strength is normal.
Class II	Mild weakness affecting muscles other than ocular muscles; may also have ocular muscle weakness of any severity. • IIa. Predominantly affecting limb, axial muscles, or both. May also have lesser involvement of oropharyngeal muscles • IIb. Predominantly affecting oropharyngeal, respiratory muscles, or both. May also have lesser or equal involvement of limb, axial muscles, or both.

Class III	Moderate weakness affecting muscles other than ocular muscles; may also have ocular muscle weakness of any severity. ● IIIa. Predominantly affecting limb, axial muscles, or both. May also have lesser involvement of oropharyngeal muscles. ● IIIb. Predominantly affecting oropharyngeal, respiratory muscles, or both. May also have lesser or equal involvement of limb, axial muscles, or both.
Class IV	Severe weakness affecting muscles other than ocular muscles; may also have ocular muscle weakness of any severity. ● IVa. Predominantly affecting limb, axial muscles, or both. May also have lesser involvement of oropharyngeal muscles. ● IVb. Predominantly affecting oropharyngeal, respiratory muscles, or both. May also have lesser or equal involvement of limb, axial muscles, or both
Class V	Defined as intubation, with or without mechanical ventilation, except when employed during routine postoperative management. The use of a feeding tube without intubation places the patient in class IVb.

POLICY HISTORY

Date	Summary
March 2025	● Updated Soliris HCPCS Code ● Updated age minimum for Soliris in MG
March 2025	● Addition of Bkemv & Epsyqli
August 2024	● Addition of Soliris ● Addition of 2 indications: NMOSD & MG
February 2023	● Updated initial authorization duration to 1 year
March 2022	● New Guideline

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Administrative Services Medical Policy Committee

Disclaimer

Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.

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