Clinical Policy Title:	ravulizumab-cwvz
Policy Number:	RxA.289
Drug(s) Applied:	Ultomiris®
Original Policy Date:	02/07/2020
Last Review Date:	10/19/2023
Line of Business Policy Applies to:	All lines of Business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Paroxysmal Nocturnal Hemoglobinuria (must meet all)**:**

1. Diagnosis of PNH;
2. Prescribed by or in consultation with a hematologist;
3. Age ≥ 1 month;
4. Flow cytometry shows detectable GPI-deficient hematopoietic clones or ≥ 5% PNH cells;
5. Ultomiris® is not prescribed concurrently with Empaveli™ or Soliris®;
6. Member meets one of the following (a or b):
   a. History of ≥ 1 red blood cell transfusion in the past 24 months (i or ii):
      i. Documentation of hemoglobin < 7 g/dL in members without anemia symptoms;
      ii. Documentation of hemoglobin < 9 g/dL in members with anemia symptoms;
   b. History of thrombosis;
7. Dose does not exceed (a, b, and c):
   a. If member is switching therapy from Soliris®, administration of the loading dose should occur 2 weeks after the last Soliris® infusion;
   b. Loading dose (Day 1) does not exceed the weight-based loading dose in the Dosing Information;
   c. Maintenance dose (Day 15 and every 4 or 8 weeks thereafter) does not exceed the weight-based maintenance dose in the Dosing Information.

Approval Duration
Commercial: 6 months
Medicaid: 6 months

B. Atypical Hemolytic Uremic Syndrome (must meet all):

1. Diagnosis of aHUS;
2. Prescribed by or in consultation with a nephrologist or hematologist;
3. Age ≥ 1 month;
4. Documentation that patient does not have Shiga toxin E.coli infection;
5. Documentation that patient does not have ADAMTS13 deficiency;
6. Member has signs of TMA as evidenced by all of the following (a, b, and c):
   a. Platelet count ≤ 150 x 109 /L;
   b. Hemolysis such as an elevation in serum lactate dehydrogenase (LDH);
   c. Serum creatinine above the upper limits of normal or member requires dialysis;
7. Member meets all of the following (a, b, and c):

a. If member is switching therapy from Soliris®, administration of the loading dose should occur 2 weeks after the last Soliris® infusion;
b. Loading dose (Day 1) does not exceed the weight-based loading dose in the Dosing Information;
c. Maintenance dose (Day 15 and every 4 or 8 weeks thereafter) does not exceed the weight-based maintenance dose in the Dosing Information.

Approval Duration
Commercial: 6 months
Medicaid: 6 months

C. Generalized Myasthenia Gravis (must meet all)
1. Diagnosis of gMG;
2. Prescribed by or in consultation with a neurologist;
3. Age ≥ 18 years;
4. Myasthenia Gravis Activities of Daily Living (MG-ADL) score ≥ 6 at baseline;
5. Myasthenia Gravis Foundation of America (MGFA) clinical classification of Class II to IV;
6. Member has positive serological test for anti-AChR antibodies;
7. Trial and failure of a corticosteroid, unless contraindicated or clinically significant adverse effects are experienced;
8. Trial and failure of a cholinesterase inhibitor, unless contraindicated or clinically significant adverse effects are experienced;
9. Trial and failure of two immunosuppressive therapies, unless clinically significant adverse effects are experienced or all are contraindicated;
10. Ultomiris® is not prescribed concurrently with Soliris®;
11. Dose does not exceed the following (a, b, and c):
    a. Loading dose on Day 1:
        i. Weight ≥ 40 to < 60 kg: 2,400 mg;
        ii. Weight ≥ 60 to < 100 kg: 2,700 mg;
        iii. Weight ≥ 100 kg: 3,000 mg;
    b. If member is switching therapy from Soliris, administration of the loading dose should occur 2 weeks after the last Soliris infusion;
    c. Maintenance dose on Day 15 and at the specified frequency thereafter:
        i. Weight ≥ 40 to < 60 kg: 3,000 mg every 8 weeks;
        ii. Weight ≥ 60 to < 100 kg: 3,300 mg every 8 weeks;
        iii. Weight ≥ 100 kg: 3,600 mg every 8 weeks.

Approval Duration
Commercial: 6 months
Medicaid: 6 months

II. Continued Therapy Approval

A. Paroxysmal Nocturnal Hemoglobinuria (must meet all):
1. Member is currently receiving medication that has been authorized by RxAdvance or the member has met initial approval criteria listed in this policy;
2. Member is responding positively to therapy as evidenced by, including but not limited to, improvement in any of the following parameters:
    a. Improved measures of intravascular hemolysis (e.g., normalization of lactate dehydrogenase [LDH]);
    b. Reduced need for red blood cell transfusions;
    c. Increased or stabilization of hemoglobin levels;
    d. Less fatigue;

e. Improved health-related quality of life;
f. Fewer thrombotic events.

3. If request is for a dose increase, new dose does not exceed the weight-based maintenance dose in the Dosing Information.

Approval Duration
Commercial: 6 months
Medicaid: 6 months

B. Atypical Hemolytic Uremic Syndrome (must meet all):

1. Member is currently receiving medication that has been authorized by RxAdvance or the member has met initial approval criteria listed in this policy ;
2. Member is responding positively to therapy as evidenced by one of the following parameters (a, b, c, d, or e):
   a. Increase in Platelet count;
   b. decrease in serum creatinine;
   c. decrease in serum LDH;
   d. Reduced need for red blood cell transfusions;
   e. Reduced need for dialysis.
3. If request is for a dose increase, new dose does not exceed the weight-based maintenance dose in the Dosing Information.

Approval Duration
Commercial: 6 months
Medicaid: 6 months

C. Generalized Myasthenia Gravis (must meet all)

1. Member is currently receiving medication that has been authorized by RxAdvance or the member has met initial approval criteria listed in this policy;
2. Member is responding positively to therapy as evidenced by, Improved MG-ADL assessment score as evidenced by a 2-point reduction from baseline;
3. Ultomiris® is not prescribed concurrently with Soliris®
4. If request is for a dose increase, new dose does not exceed the weight-based maintenance dose in the Dosing Information.

   Approval Duration
   Commercial: 6 months
   Medicaid: 6 months

References

1. Parker C, Omine M, Richards S, et al. Diagnosis and management of paroxysmal nocturnal hemoglobinuria. Blood 2005; 106(12):3699-3709. doi:10.1182/blood-2005-04-1717. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1895106/. Accessed October 03, 2022.
2. Sanders DB, Wolfe GI, Benatar M, et al. International consensus guidelines for the management of myasthenia gravis. Neurology. 2016; 87: 419-425. Available at: https://n.neurology.org/content/87/4/419. Accessed October 03, 2022.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	01/2020	02/07/2020

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy was reviewed: 1. Policy title table was updated. 2. Line of Business Policy Applies to was update to all lines of business. 3. PNH approval duration updated to specify Medicaid, HIM and Commercial approval durations. 4. Criteria for aHUS was added. 5. Continued Therapy criteria II.A.1 was rephrased to "Currently receiving medication that has been authorized by RxAdvance..." in PNH and Continued Therapy criteria was added for aHUS. 6. References were updated.	07/03/2020	09/14/2020
Policy was reviewed: 1. Initial Approval Criteria and Continued Therapy Approval Criteria were updated to remove HIM approval duration. 2. Continued Therapy Approval Criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance...". 3. Continued Therapy Approval Criteria II.B.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance...". 4. References were reviewed and updated.	07/12/2021	09/14/2021
Policy was reviewed: 1. References were reviewed and updated.	02/07/2022	04/18/2022
Policy was reviewed: 1. Initial Approval Criteria, 1.A.5: Updated to include new prescriber criteria Ultomiris® is not prescribed concurrently with Empaveli™ or Soliris®. 2. Initial Approval Criteria, I.B.6: Updated to include new diagnostic criteria Member has signs of TMA as evidenced by all of the following (a, b, and c): a. Platelet count ≤ 150 x 109 /L; b. Hemolysis such as an elevation in serum lactate dehydrogenase (LDH); c. Serum creatinine above the upper limits of normal or member requires dialysis	10/03/2022	10/19/2022

Review/Revision History	Review/Revised Date	P&T Approval Date
3. Initial Approval Criteria, I.C.: Updated to include approval criteria for indication, myasthenia gravis (gMG). 4. Continued Therapy Approval Crtieria, II.C.: Updated to include approval criteria for indication, myasthenia gravis (gMG). 5. References were reviewed and updated.		
Policy was reviewed.	10/19/2023	10/19/2023