Clinical Policy Title:	pegcetacoplan
Policy Number:	RxA.692
Drug(s) Applied:	Empaveli™
Original Policy Date:	08/16/2021
Last Review Date:	09/14/2021
Line of Business Policy Applies to:	All lines of business

Background

Pegcetacoplan (Empaveli™) is a complement inhibitor that binds to complement protein C3 and its activation fragment C3b, indicated for the treatment of adult patients with paroxysmal nocturnal hemoglobinuria (PNH).

Dosing Information

Drug Name	Indication	Dosing Regimen	Maximum Dose
pegcetacoplan (Empaveli™)	PNH	1,080 mg* by subcutaneous infusion twice weekly via a commercially available pump.	1,080 mg via subcutaneous infusion twice weekly.

* For LDH levels greater than 2 × the upper limit of normal (ULN), adjust the dosing regimen to 1,080 mg every three days.

Dosage Forms

- Injection: 1,080 mg/20 mL (54 mg/mL) in a single-dose vial.

Clinical Policy

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria. The provision of provider samples does not guarantee coverage under the terms of the pharmacy benefit administered by RxAdvance. All criteria for initial approval must be met in order to obtain coverage.

I. Initial Approval Criteria

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

1. Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) confirmed by flow cytometry;
2. Age ≥ 18 years;
3. Prescribed by or in consultation with a hematologist, oncologist, or immunologist;
4. Member has been vaccinated against encapsulated bacteria according to current ACIP guidelines at least 2 weeks prior to starting Empaveli™;
5. Member is transfusion-dependent with hemoglobin ≤ 7 g/dL or ≤ 9g/Dl and experiencing symptoms of anemia;
6. Member has documented symptoms of thromboembolic complications (abdominal pain, shortness of breath, chest pain, organ damage);

7. If the member is switching from Soliris®(eculizumab), Soliris® (eculizumab) should be continued for the first 4 weeks after starting the requested agent and then Soliris® (eculizumab) should be discontinued;
8. If the member is switching from Ultomiris®, initiate Empaveli™ no more than 4 weeks after the last dose of Ultomiris®;
9. Dose does not exceed 1,080 mg via subcutaneous infusion twice weekly.

Approval Duration
Commercial: 12 months
Medicaid: 12 months

II. Continued Therapy Approval

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

1. Member is currently receiving medication that has been authorized by RxAdvance or member has previously met initial approval criteria listed in this policy;
2. Member is responding positively to therapy as evidenced by decreased requirement of RBC transfusions, stabilization/improvement of hemoglobin, reduction of lactate dehydrogenase (LDH), stabilization/improvement of symptoms;
3. Member will not be using the requested agent in combination with Soliris® (eculizumab) or Ultomiris® (ravulizumab-cwvz);
4. If request is for a dose increase, dose does not exceed 1,080 mg via subcutaneous infusion twice weekly.

Approval Duration
Commercial: 12 months
Medicaid: 12 months

III. Appendices

APPENDIX A: Abbreviation/Acronym Key
PNH: Paroxysmal Nocturnal Hemoglobinuria
LDH: lactate dehydrogenase
ACIP: Advisory Committee on Immunization Practices
RBC: red blood cells
ULN: upper limit of normal
aPTT: activated partial thromboplastin time

APPENDIX B: Therapeutic Alternatives
Below are suggested therapeutic alternatives based on clinical guidance. Please check drug formulary for preferred agents and utilization management requirements.

Drug Name	Dosing Regimen	Maximum Dose
Soliris®	600 mg weekly for the first 4 weeks, followed by 900 mg for the fifth dose 1 week later, then 900 mg every 2 weeks thereafter.	900 mg intravenous infusion/dose
Ultomiris®	<u>Loading dose</u> 40 to <60 kg: 2400 mg intravenously ≥60 to <100 kg: 2700 mg intravenously ≥100 kg: 3000 mg intravenously <u>Maintenance dose</u>	Weighing 100 kg or more: 3,000 mg intravenous load; 3,600 mg/dose intravenous every 8 weeks maintenance dose. Weighing 60 to 99 kg: 2,700 mg intravenous load; 3,300 mg/dose

Drug Name	Dosing Regimen	Maximum Dose
	Initiate maintenance doses 2 weeks after loading dose Dosing schedule allows for occasionally variation within 7 days of the scheduled infusion day (except for the first maintenance dose), but administer subsequent doses according to original schedule 40 to <60 kg: 3000 mg intravenously every 8 weeks ≥60 to <100 kg: 3300 mg intravenously every 8 weeks ≥100 kg: 3600 mg intravenously every 8 weeks	intravenous every 8 weeks maintenance dose. Weighing to 59 kg: 2,400 mg intravenous load; 3,000 mg/dose intravenous every 8 weeks maintenance dose.

Therapeutic alternatives are listed as generic (Brand name®) when the drug is available by both generic and brand, Brand name® when the drug is available by brand only and generic name when the drug is available by generic only.

APPENDIX C: Contraindications/Boxed Warnings

- Contraindication(s):
  - Patients with hypersensitivity to pegcetacoplan or any of the excipients.
  - Patients who are not currently vaccinated against certain encapsulated bacteria unless the risks of delaying Empaveli™ treatment outweigh the risks of developing a serious bacterial infection with an encapsulated organism.
  - Patients with unresolved serious infection caused by encapsulated bacteria.

- Boxed Warning(s):
  - Serious infections caused by encapsulated bacteria.

APPENDIX D: General Information

- Use caution when administering Empaveli™ to patients with:
  - Serious infections caused by encapsulated bacteria.
  - Infusion-Related Reactions: Monitor patients for infusion-related reactions and institute appropriate medical management as needed.
  - Interference with Laboratory Tests: Use of silica reagents in coagulation panels may result in artificially prolonged activated partial thromboplastin time (aPTT).

References

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Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	08/16/2021	09/14/2021