RX.PA.032.MPC Eculizumab (Soliris)® & Biosimilars

The purpose of this policy is to define the prior authorization process for Soliris® (eculizumab) & biosimilars, Bkemv (eculizumab-aeeb) and Epysqli (eculizumab-aagh).

Soliris® (eculizumab) and biosimilars are indicated for the select or all of the following:

- Treatment of patients with paroxysmal nocturnal hemoglobinuria (PNH) to reduce hemolysis
- Treatment of patients with atypical hemolytic uremic syndrome (aHUS) to inhibit complement-mediated thrombotic microangiopathy
    - Limitations of use: eculizumab is not indicated for the treatment of patients with Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS)
- Treatment of adult patients with generalized Myasthenia Gravis (gMG) who are anti-acetylcholine receptor (AChR) antibody positive
- Treatment of neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive

DEFINITIONS

Atypical Hemolytic Uremic Syndrome (aHUS) – a rare autoimmune disorder that results in low red blood cell counts, low platelet counts, and acute renal failure

Lactate Dehydrogenase (LDH) – a catalytic enzyme that is highly concentrated in red blood cells. Increased serum levels of LDH correlate with increased hemolysis of red blood cells.

Neuromyelitis optica spectrum disorder (NMOSD) - also known as Devic disease, is a chronic disorder of the brain and spinal cord dominated by inflammation of the optic nerve (optic neuritis) and inflammation of the spinal cord (myelitis).

Paroxysmal Nocturnal Hemoglobinuria (PNH) – a rare disorder where the immune system attacks red blood cells, resulting in anemia and thrombosis

PROCEDURE

A. Initial Authorization Criteria:

	Products
Preferred	• **Soliris® (eculizumab)**
Non-preferred	• **Bkemv ® (eculizumab-aeeb)** • **Epysqli ® (eculizumab-aagh)**

- For requests for non-preferred products, must have documented trial and failure or intolerance or contraindication to ALL preferred product(s).

Must meet all of the criteria listed under the respective diagnosis:

1. Paroxysmal Nocturnal Hemoglobinuria (PNH)

- Must be prescribed by or in consultation with a hematologist, oncologist, immunologist or genetic specialist
- Member must be 18 years of age or older
- 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 had at least one blood transfusion within the last 12 months and one of the following:
  - Hemoglobin (Hgb) ≤ 7 g/dL
  - Hemoglobin (Hgb) ≤ 9 g/dL with symptoms of anemia
- Must have an LDH level of 1.5 times the upper limit of the normal range (laboratory result with reference range must be submitted)
- Eculizumab is not prescribed concurrently with Empaveli or Ultomiris, unless the member is in a 4-week period of cross-titration between Eculizumab and Empaveli
- Must provide documentation that a meningococcal vaccine was given at least two (2) weeks prior to the administration of the first dose of Eculizumab
- Verification prescriber and patient are enrolled in the REMS Program

2. Atypical Hemolytic Uremic Syndrome (aHUS)

- Must be prescribed by or in consultation with a nephrologist, hematologist, oncologist, immunologist or genetic specialist
- Patient must weigh ≥ 5kg
- Must have a diagnosis of atypical hemolytic uremic syndrome
- ADAMTS 13 activity level above 5%
- Absence of Shiga toxin
- Eculizumab is not prescribed concurrently with Ultomiris
- Must provide documentation that a meningococcal vaccine was given at least two (2) weeks prior to the administration of the first dose of Eculizumab
- Verification prescriber and patient are enrolled in the REMS Program

3. Generalized Myasthenia Gravis (gMG)

- Must be prescribed by or in consultation with a neurologist
- Must have a diagnosis of Myasthenia Gravis
- Member must be 6 years of age or older
- Must be anti-acetylcholine receptor (AChR) antibody positive
- Myasthenia Gravis Foundation of America (MGFA) clinical classification II to IV
- Myasthenia Gravis-Activities of Daily Living (MG-ADL) score greater than or equal to 6 at baseline
- Documented failed treatment to at least two immunosuppressive therapies or contraindication/intolerance to all listed below:
    - Azathioprine
    - Cyclosporine
    - Mycophenolate mofetil
    - Tacrolimus
    - Methotrexate
    - Cyclophosphamide
- Eculizumab is not prescribed concurrently with Ultomiris
- Must provide documentation that a meningococcal vaccine was given at least two (2) weeks prior to the administration of the first dose of Eculizumab
- Verification prescriber and patient are enrolled in the REMS Program

4. Neuromyelitis optica spectrum disorder (NMOSD)

- Must be prescribed by or in consultation with a neurologist
- Must have a diagnosis of neuromyelitis optica spectrum disorder

- Member must be 18 years of age or older
- Must be anti-aquaporin-4 (AQP4) antibody positive
- Member exhibits one of the following core clinical characteristics of NMOSD:
  - 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
- Must provide documentation that a meningococcal vaccine was given at least two (2) weeks prior to the administration of the first dose of Eculizumab
- Member must not be receiving the requested drug concomitantly with other biologics indicated for NMOSD
- Verification prescriber and patient are enrolled in the REMS Program

B. Must be prescribed at a dose within the manufacturer's dosing guidelines (based on diagnosis, weight, etc) listed in the FDA approved labeling.

C. Eculizumab will be considered investigational or experimental for any other use and will not be covered.

D. <u>Reauthorization Criteria:</u>

	Products
Preferred	• **Soliris® (eculizumab)**
Non-preferred	• **Bkemv ® (eculizumab-aeeb)** • **Epysqli ® (eculizumab-aagh)**

- For requests for non-preferred products, must have documented trial and failure or intolerance or contraindication to ALL preferred product(s).

All prior authorization renewals are reviewed on an annual basis to determine the Medical Necessity for continuation of treatment. Authorization may be extended at 1-year intervals based upon:

MPC Renewal:

- Chart documentation from the prescriber that the member's condition has improved based upon the prescriber's assessment while on therapy.
- For Generalized myasthenia gravis (gMG) and Neuromyelitis optica spectrum disorder (NMOSD):
  - Must be prescribed by or in consultation with a neurologist
- For Paroxysmal Nocturnal Hemoglobinuria (PNH):
  - Must be prescribed by or in consultation with a hematologist, oncologist, immunologist or genetic specialist
- For Atypical Hemolytic Uremic Syndrome (aHUS):
  - Must be prescribed by or in consultation with a nephrologist, hematologist, oncologist, immunologist or genetic specialist

Renewal from Previous Insurer:

- Members who have received prior approval (from insurer other than MPC), or have been receiving medication samples, should be considered under criterion A (Initial Authorization Criteria)
- Provider has documented clinical response of the member's condition which has stabilized or improved based upon the prescriber's assessment

LIMITATIONS:

Length of Authorization (if above criteria met)		
Initial Authorization	Up to 3 months	
Reauthorization	Up to 1 year	
Place of Service	When Eculizumab is administered at any place of service other than 011 and 012, the service will be reviewed for medical necessity. The place of service codes are outlined below.	
Place of Service Code(s)	**Place of Service Name**	**Place of Service Description**

011	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
012	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.

CODES: J CODES(S)

Code	Description
J1299	Injection, eculizumab, 2mg
Q5151	Injection, eculizumab-aagh (epysqli), biosimilar, 2mg
Q5152	Injection, eculizumab-aeeb (bkemv), biosimilar, 2mg

REFERENCES

1. Bkemv [prescribing information]. Thousand Oaks, CA: Amgen Inc.; May 2024.
2. Epysqli [prescribing information]. Yeonsu-gu, Incheon: Samsung Bioepis Co., Ltd.; July 2024.
3. Soliris [prescribing information]. Cheshire, CT: Alexion Pharmaceuticals, Inc.; October 2017.
4. Parker C. Eculizumab for paroxysmal nocturnal haemoglobinuria. Lancet 2009;373:759-67
5. Hillmen P, Young NS, Schubert J, et al. The complement inhibitor eculizumab in paroxysmal nocturnal hemoglobinuria. N Engl J Med 2006;355:1233-43.
6. Brodsky RA, Young NS, Antonioli E, et al. Multicenter phase 3 study of the complement inhibitor eculizumab for the treatment of patients with paroxysmal nocturnal hemoglobinuria. Blood 2008;111:1840-1847.
7. Hill A, Richards J, Hillmen P, et al. Recent developments in the understanding and management of paroxysmal nocturnal haemoglobinuria. British Journal of Haematology 2007; 137:181-192.
8. Kelly RJ, Hill A, Arnold, LM, et al. Long-term treatment with eculizumab in paroxysmal nocturnal hemoglobinuria: sustained efficacy and improved survival. Blood 2011;117:6786-6792.
9. Taylor CM, Machin S, Wigmore SJ, et al. Clinical practice guidelines for the management of atypical haemolytic uraemic syndrome in the United Kingdom. British Journal of Haematology 2009;148;37-47
10. Kavanagh D, Goodship T. Atypical hemolytic uremic syndrome. Curr Opin Hematol 2010;17;432-438.

REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	DATE APPROVED
Update to include preferred vs non-preferred medication table in the reauthorization criteria	*07/2026*

DESCRIPTION OF REVIEW / REVISION	DATE APPROVED
Annual review	*02/2026*
Addition of Eculizumab biosimilar products to criteria *Update in age requirement of Myasthenia Gravis to 6 years of age and older*	*04/2025*
Annual Review	*02/2025*
Selected Revision *Addition of renewal criteria requirement for prescriber specialty per indication*	*11/2024*
Annual Review *Change in Non-MPC renewal to renewal from previous insurer*	*02/2024*
Annual review	*02/2023*
Selected Revision *Addition of MPC vs Non-MPC Renewal*	*10/2022*
Annual review	*02/2022*
Addition of dosing requirements and off-label restrictions	*12/2021*
P&T Review	*11/2020*