Mass General Brigham
Health Plan

Complement Inhibitors and Miscellaneous Immunosuppressive Agents
Izervay (avacincaptad pegol)
Effective 02/18/2025

Plan	☒ MassHealth UPPL ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☐ Pharmacy Benefit ☒ Medical Benefit		
Specialty Limitations	N/A		
Contact Information	**Medical and Specialty Medications** All Plans | Phone: 877-519-1908 | Fax: 855-540-3693 **Non-Specialty Medications** All Plans | Phone: 800-711-4555 | Fax: 844-403-1029		
Notes	Additional agents from this class are available through the pharmacy benefit. Please see the MassHealth Drug List for coverage and criteria.		

Overview
Izervay (avacincaptad pegol) is indicated for the treatment of geographic atrophy (GA) secondary to age-related macular degeneration (AMD).

Coverage Guidelines
Authorization may be reviewed on a case by case basis for members who are new to the plan currently receiving treatment with requested medication excluding when the product is obtained as samples or via manufacturer's patient assistance programs.
OR
Authorization may be granted for members when all the following criteria are met:

1. Diagnosis of GA secondary to AMD
2. Prescriber is an ophthalmologist
3. Member is ≥ 50 years of age
4. Absence of choroidal neovascularization (CNV or Wet-AMD) in the treatment eye
5. Normal luminance best corrected visual acuity (BCVA) ≥24 letters (20/320 Snellen equivalence)
6. Total GA lesion area ≥2.5 and ≤17.5 mm2, with at least 1 lesion ≥1.25 mm2 if GA is multifocal.
7. Presence of any pattern of hyperautofluorescence in the junctional zone of GA.
8. Requested dosing is 2mg (0.1 mL) every 28 days

Continuation of Therapy
Prescriber must provide documentation of **ALL** of the following:

1. Positive response to therapy
2. Member has not developed nAMD (wet AMD)
3. Total treatment duration ≤ 1 year.

Limitations

1. Initial approval duration will be granted for 6 months.

2. There is currently no data supporting dosing of this agent for > 1 year. Recertification may be granted for total approval duration of 1 year.

References

1. Izervay® [package insert]. Parsippany (NJ): Iveric Bio, Inc,; 2023 Aug

Review History

4/10/24 – Created for P&T. Adopted MH criteria. Izervay will require PA under MB. Effective 5/6/24.
1/2025 – Reviewed and updated for P&T. Formatting updates made to the header. Effective 2/18/25