Mass General Brigham
Health Plan

Complement Inhibitors and Miscellaneous Immunosuppressive Agents
Enjaymo (sutimlimab-jome)
Soliris (eculizumab)
Tavneos (avacopan)
Syfovre (pegcetacoplan)
Uplizna (inebilizumab-cdon)
Vyvgart (efgartigimod alfa-fcab)
Effective 05/06/2024

Plan	☒ MassHealth UPPL ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☒ Medical Benefit		
Specialty Limitations	Tavneos (avacopan) have been designated specialty and must be filled at a contracted specialty pharmacy.		
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		
Exceptions	N/A		

Overview

Enjaymo (sutimlimab-jome) is an immunoglobulin G (IgG), subclass 4 monoclonal antibody that is indicated to decrease the need for red blood cell (RBC) transfusion due to hemolysis in adults with cold agglutinin diseases (CAD).

Rystiggo (rozanolixizumab-noli) is a neonatal Fc receptor blocker indicated for the treatment of gMG in adult patients who are anti-AChR or anti-MuSK antibody positive.

Soliris (eculizumab) is indicated for the treatment of atypical hemolytic uremic syndrome (aHUS), generalized myasthenia gravis (MG), neuromyelitis optica spectrum disorder (NMOSD), and paroxysmal nocturnal hemoglobinuria (PNH).

Tavneos (avacopan) is an oral agent. It is a first-in class complement 5a receptor (C5aR) antagonist indicated as an adjunctive treatment of adult patients with severe active anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis (AAV) including the two main types: granulomatosis with polyangiitis (GPA) and microscopic polyangiitis (MPA) in combination with standard therapy including glucocorticoids.

Syfovre (pegcetacoplan) is indicated for the treatment of geographic atrophy (GA) secondary to age-related macular degeneration (AMD).

Uplizna (inebilizumab-cdon) is a CD19-directed cytolytic antibody that is presumed to be involved in CD19 binding. Following binding, inebilizumab-cdon depletes lymphocytes derived from B-cell lineage.

Vyvgart (efgartigimod alfa-fcab) is indicated for the treatment of gMG in adult patients who are anti- AChR antibody positive.

Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) is a subcutaneous product combination of efgartigimod alfa, a human IgG1 antibody fragment marketed for intravenous use as Vyvgart (efgartigimod alfa), and recombinant human hyaluronidase PH20 (rHuPH20), which is Halozyme's ENHANZE® drug delivery technology to increase permeability of the subcutaneous tissue by depolymerizing hyaluronan, facilitating subcutaneous delivery of biologics.

No PA	Drugs that require PA
Complement Inhibitors	
	Enjaymo® (sutimlimab-jome) MB
	Soliris® (eculizumab) MB
	Tavneos® (avacopan)
	Syfovre (pegcetacoplan) MB
Miscellaneous Immunosuppressive Agents	
	Rystiggo (rozanolixizumab-noli) MB
	Uplizna® (inebilizumab-cdon) MB
	Vyvgart® (efgartigimod alfa-fcab) MB
	Vyvgart Hytrulo® (efgartigimod alfa and hyaluronidase-qvfc) MB

MB – Medical Benefit only. This drug is available through the health care professional who administers the drug or in an outpatient or inpatient hospital setting.

Coverage Guidelines
Authorization may be granted for members new to the plan who are currently receiving treatment with the requested product 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:

Enjaymo (sutimlimab-jome)
ALL of the following:

1. Diagnosis of cold agglutinin disease (CAD)
2. Member is ≥18 years of age
3. Member has had ≥1 blood transfusion in the last 6 months
4. Hb ≤10 g/dL (dated within the last 60 days)
5. Member has received a vaccine against encapsulated bacteria (Neisseria meningitidis, Haemophilus influenzae, and Streptococcus pneumoniae) at least two weeks prior to treatment initiation
6. Appropriate dosing

Rystiggo (rozanolixizumab-noli)
Generalized Myasthenia Gravis

1. Diagnosis of Generalized Myasthenia Gravis
2. Member is ≥18 years of age
3. Member is AChR or MuSK antibody positive

4. Prescriber is a neurologist or consult notes from a neurology office are provided
5. Physician attestation of inadequate response, adverse reaction, or contraindication to pyridostigmine
6. Physician attestation of inadequate response or adverse reaction to **TWO** of the following or contraindication to **ALL** of the following immunosuppressant trials
    a. azathioprine
    b. cyclosporine
    c. glucocorticoids (e.g., prednisone)
    d. mycophenolate
    e. tacrolimus
7. **ONE** of the following:
    a. Inadequate response, adverse reaction, or contraindication to Vyvgart (efgartigimod alfa-fcab) or Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)
    b. Member is MuSK antibody positive
8. Appropriate dosing

Soliris (eculizumab)

Atypical hemolytic-uremic syndrome (aHUS)

ALL of the following:

1. Diagnosis of atypical hemolytic-uremic syndrome (aHUS)
2. Member has received a meningococcal vaccine at least two weeks prior to treatment initiation
3. Appropriate dosing

Generalized Myasthenia Gravis

ALL of the following:

1. Diagnosis of Generalized Myasthenia Gravis
2. Member is ≥18 years of age
3. Member is AchR antibody positive
4. Prescriber is a neurologist or consult notes from a neurology office are provided
5. Physician attestation of inadequate response, adverse reaction, or contraindication to pyridostigmine
6. Physician attestation of inadequate response or adverse reaction to **TWO** of the following or contraindication to **ALL** of the following immunosuppressant trials
    a. azathioprine
    b. cyclosporine
    c. glucocorticoids (e.g., prednisone)
    d. mycophenolate
    e. tacrolimus
7. Member has received a meningococcal vaccine at least two weeks prior to treatment initiation
8. Appropriate dosing

Neuromyelitis optica spectrum disorder (NMOSD)

ALL of the following:

1. Diagnosis of neuromyelitis optica spectrum disorder
2. Documentation of a positive serologic test for anti-aquaporin-4 (AQP4)
3. Member is ≥18 years of age
4. Member has received a meningococcal vaccine at least two weeks prior to treatment initiation
5. Appropriate dosing

Paroxysmal nocturnal hemoglobinuria (PNH)

ALL of the following:

1. Appropriate diagnosis
2. Member has received a meningococcal vaccine at least two weeks prior to treatment initiation
3. Appropriate dosing
4. Member is ≥18 years of age

PLE/CHAPLE (off-label indication)

ALL of the following:

1. Diagnosis of CD55-deficient protein-losing enteropathy (PLE), or complement hyperactivation, angiopathic thrombosis, and protein-losing enteropathy (CHAPLE) disease
2. Member is ≥2 months of age
3. Member has received a meningococcal vaccine at least two weeks prior to treatment initiation
4. Prescriber is a specialist in rare genetic or hematologic diseases or consult notes from specialist are provided
5. Results from genetic testing confirming a CD55 loss-of-function mutation
6. Appropriate dosing

Syfovre (pegcetacoplan)

Dry-AMD

ALL of the following:

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 15mg (0.1 mL) once every 25 days to 60 days

Tavneos (avacopan)

ALL of the following:

1. Diagnosis of severe active anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis (e.g., granulomatosis with polyangiitis [GPA], microscopic polyangiitis [MPA])
2. Member is ≥18 years of age
3. Prescriber is a rheumatologist or nephrologist or consult notes from a rheumatologist or nephrologist are provided
4. Physician attestation that the requested agent will be used as adjunctive therapy with **BOTH** of the following:
    a. A systemic glucocorticoid
    b. **ONE** of the following:
        i. azathioprine
        ii. cyclophosphamide
        iii. methotrexate
        iv. mycophenolate mofetil
        v. rituximab
5. Appropriate dosing
6. Requested quantity is ≤ 6 capsules per day

Uplizna (inebilizumab-cdon)
ALL of the following:

1. Diagnosis of neuromyelitis optica spectrum disorder (NMOSD)
2. Documentation of a positive serologic test for anti-aquaporin-4 (AQP4)
3. Member is ≥18 years of age
4. **If reviewing under pharmacy benefit:** Physician attestation of inadequate response, adverse reaction or contraindication to Enspryng® (satralizumab-mwge)
5. Appropriate dosing

Vyvgart (efgartigimod alfa-fcab)
Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)
ALL of the following:

1. Diagnosis of Generalized Myasthenia Gravis
2. Member is ≥18 years of age
3. Member is AChR antibody positive
4. Prescriber is a neurologist or consult notes from a neurology office are provided
5. Physician attestation of inadequate response, adverse reaction, or contraindication to pyridostigmine
6. Physician attestation of inadequate response or adverse reaction to **TWO** of the following or contraindication to **ALL** of the following immunosuppressant trials
    a. azathioprine
    b. cyclosporine
    c. glucocorticoids (e.g., prednisone)
    d. mycophenolate
    e. tacrolimus
7. Appropriate dosing

Continuation of Therapy
aHUS/PNH/NMOSD: Reauthorization by physician will infer a positive response to therapy.

AMD (Syfovre):

1. Positive response to therapy
2. Member has not developed nAMD (wet AMD)
3. If requested dosing is ≥ every 60 days, prescriber has assessed using less frequent dosing

CAD/Generalized MG (Soliris)/GPA/MPA: Reauthorization requires physician documentation of a positive response to therapy.

Generalized MG (Vyvgart): Reauthorization by physician will infer a positive response to therapy.

PLE/CHAPLE disease
Medical records documenting **ALL** of the following:

1. Improvement or no worsening of clinical symptoms (e.g., abdominal pain, bowel movements, facial and peripheral edema)
2. **ONE** of the following:
    a. Increase in current serum albumin concentration from baseline serum albumin concentration
    b. Serum albumin concentration stabilized above lower threshold for normal range (≥3.5 g/dL)
3. **ONE** of the following:
    a. Increase in current serum IgG concentration from baseline serum IgG concentration

a. Serum IgG concentration stabilized above lower threshold for age-adjusted normal range *(See appendix for table of age-adjusted normal serum IgG concentration ranges)*

Limitations

1. Initial approvals will be granted for the following:
    a. aHUS/PNH/NMOSD, PLE/CHAPLE: 1 year
    b. Generalized MG (Rystiggo): 3 months
    c. CAD/Generalized MG (Soliris)/GPA/MPA/AMD (Syfovre): 6 months
    d. Generalized MG (Vyvgart, Vyvgart Hytrulo): 2 months
2. Reauthorizations will be granted for the following:
    a. Generalized MG (Vyvgart, Vyvgart Hytrulo): 2 months
    b. Generalized MG (Rystiggo): 3 months
    c. All other indications: 1 year
3. **Requests for Brand Name when generic is preferred:** In addition to any prior authorization requirements that may be listed above, if an A-rated generic equivalent is available, such prior authorization requests require medical records documenting an allergic response, adverse reaction, or inadequate response to the generic equivalent drug (history of allergic reaction to the inactive ingredients used in the manufacturing process of a certain drug is acceptable).
4. **Requests for generic when Brand Name is preferred:** There are some drugs for which the Plan has determined it will be cost effective to prefer the use of the Brand Name formulation. In this case, the generic equivalent formulation is considered non-preferred and requires prior authorization. These requests require medical records documenting an allergic response, adverse reaction, or inadequate response to the Brand Name formulation. For the most up to date list of drugs where the Brand Name formulation is preferred, see the MassHealth Brand Name Preferred Over Generic Drug List (BOGL) at www.mass.gov/druglist.

Appendix

Soliris: Age-Adjusted Serum IgG Concentration Reference Ranges

The table below shows age-adjusted serum immunoglobulin G (IgG) concentration reference ranges to assist with recertification of Soliris (eculizumab)requests indicated for CHAPLE disease. Based on a brief literature review, there does not appear to be a widely accepted set of age-adjusted IgG reference ranges, and these ranges may vary by laboratory. Therefore, if the provider submits medical records with documented serum IgG laboratory testing, reference ranges specified in the medical records may be acceptable in place of the values in the table below.

Age Group	Age-Adjusted Serum IgG Level Reference Range
≤1 month	251-1051
1-3 months	176-601
4-6 months	172-814
7-12 months	217-1213
13-24 months	424-1051
25-36 months	441-1135
3-5 years	441-1236
6-8 years	633-1280
9-11 years	608-1572
12-16 years	1066-1218
16-18 years	1188-1458

≥18 years	639-1349

References

1. Soliris® [package insert]. Cheshire (CT): Alexion Pharmaceuticals, Inc.; 2020 Nov.
2. Ultomiris® [package insert] Boston (MA): Alexion Pharmaceutical Inc; 2022 Apr.
3. Enspryng® [package insert]. South San Francisco (CA): Genentech.; 2020 Aug.
4. Uplizna® [package insert]. Gaithersburg (MD): Viela Bio.; 2021 Jul.
5. Vyvgart® [package insert]. Boston (MA): Argenx US, Inc. 2021 Dec.
6. Enjaymo® [prescribing information]. Waltham (MA): Bioverative USA Inc.; 2022 Feb.
7. Niaudet P, Boyer OG. Overview of hemolytic uremic syndrome in children. In: Mattoo TK (Ed). UpToDate [database on the internet]. Waltham (MA): UpToDate; 2021 [cited 2021 Dec 7]. Available from: http://www.utdol.com/utd/index.do.
8. Noris M, Remuzzi G. Atypical hemolytic-uremic syndrome. N Engl J Med. 2009 Oct; 361(17):1,676-87.
9. Niaudet P, Boyer OG. Complement-mediated hemolytic uremic syndrome. In: Mattoo TK (Ed). UpToDate [database on the internet]. Waltham (MA): UpToDate; 2021 [cited 2021 Dec 7]. Available from: http://www.utdol.com/utd/index.do.
10. Patriquin CJ, Kuo KHM. Eculizumab and Beyond: The Past, Present, and Future of Complement Therapeutics. Transfus Med Rev. 2019 Oct 22. pii: S0887-7963(19)30132-4.
11. Bird SJ. Diagnosis of Myasthenia Gravis. In: Shefner JM (Ed). UpToDate [database on the internet]. Waltham (MA): UpToDate; 2022 Apr 26 [cited 2022 Jun 25]. Available from: http://www.utdol.com/utd/index.do.
12. PNHSource: Paroxysmal Nocturnal Hemoglobinuria (PNH) [webpage on the Internet]. PNHSource Web site. Cheshire: PNHSource [cited 2020 April 20]. Available from: http://www.pnhsource.com/hcp/facts-about-pnh.
13. Brodsky R. Clinical manifestations and diagnosis of paroxysmal nocturnal hemoglobinuria. In: Larson RA (Ed). UpToDate [database on the internet]. Waltham (MA):UpToDate; 2021 [cited 2021 Dec 7]. Available from: http://www.utdol.com/utd/index.do.
14. Empaveli® [package insert]. Waltham (MA): Apellis Pharmaceuticals, Inc.; 2021 May.
15. Siegel Rare Neuroimmune Association. Neuromyelitis Optica Spectrum Disorder [webpage on the internet]. Powell (OH): Siegel Rare Neuroimmune Association; 2020 [cited 2020 Nov 1]. Available from: https://wearesrna.org/living-with-myelitis/disease-information/neuromyelitis-optica- spectrum-disorder/
16. Glisson CC. Neuromyelitis optica spectrum disorders. In Gonzalez-Scarano F(Ed). UpToDate [database on the Internet]. Waltham (MA): UpToDate; 2021 [cited 2021 Dec 7]. Available from: http://www.utdol.com/utd/index.do.
17. Kitley J, Leite MI, Nakashima I, et al. Prognostic factors and disease course in aquaporin-4 antibody-positive patients with neuromyelitis optica spectrum disorder from the United Kingdom and Japan. Brain. 2012 Jun;135(Pt 6):1834-49.
18. Jiao Y, Fryer JP, Lennon VA, Jenkins SM, Quek AM, Smith CY et al. Updated estimate of AQP4-IgG serostatus and disability outcome in neuromyelitis optica. Neurology. 2013 Oct;81(14):1197-1204.
19. Soliris® (eculizumab) formulary dossier. Alexion, Data on file.
20. Sherman E, Han MH. Acute and Chronic Management of Neuromyelitis Optica Spectrum Disorder. Curr Treat Options Neurol. 2015 Nov;17(11):48. PMID: 26433388.
21. Trebst C, Jarius S, Berthele A. Update on the diagnosis and treatment of neuromyelitis optica: recommendations of the Neuromyelitis Optica Study Group (NEMOS). J Neurol. 2014 Jan;261(1):1-16. PMID: 24272588.

22. Kessler RA, Mealy MA, Levy M. Treatment of Neuromyelitis Optica Spectrum Disorder: Acute, Preventive, and Symptomatic. Curr Treat Options Neurol. 2016 Jan;18(1):2.
23. Huda S, Whittam D, Bhojak M, Chamberlain J, Noonan C, Jacob A. Neuromyelitis optica spectrum disorders. Clin Med (Lond). 2019 Mar;19(2):169-176.
24. Tavneos® [package insert]. Cincinnati (OH): ChemoCentryx, Inc.; 2021 Oct.
25. FDA Approvals Roundup: Tavneos, Verzenio, Dextenza [press release on the Internet]. Rockville (MD): Regulatory Affairs Professionals Society (RAPS); 2021 Oct 13 [cited 2021 Dec 3]. Available from: https://www.raps.org/news-and-articles/news-articles/2021/10/fda-approvals-roundup-tavneos-verzenio-dextenza
26. FDA approves add-on drug for adults with rare form of blood vessel inflammation [press release on the Internet]. Rockville (MD): Food and Drug Administration (US); 2021 Oct 13 [cited 2021 Dec 3]. Available from: https://www.fda.gov/drugs/news-events-human-drugs/fda-approves-add-drug-adults-rare-form-blood-vessel-inflammation Administered for the MassHealth Pharmacy Program 21
27. Geetha D, Jefferson AJ. ANCA-Associated Vasculitis: Core Curriculum 2020. Am J Kidney Dis. 2020 Jan;75(1):124-137
28. Falk RJ, Merkel PA, King TE. Granulomatosis with polyangiitis and microscopic polyangiitis: Clinical manifestations and diagnosis. In: Basow DS (Ed). UpToDate [database on the internet]. Waltham (MA): UpToDate; 2021 [cited 2021 Nov 29]. Available from: http://www.utdol.com/utd/index.do
29. Yates M, Watts R. ANCA-associated vasculitis. Clin Med (Lond). 2017 Feb;17(1):60-64.
30. Merkel PA, Kaplan AA, Falk RJ. Granulomatosis with polyangiitis and microscopic polyangiitis: Induction and maintenance therapy. In: Basow DS (Ed). UpToDate [database on the internet]. Waltham (MA): UpToDate; 2021 [cited 2021 Nov 29]. Available from: http://www.utdol.com/utd/index.do
31. Kidney Disease: Improving Global Outcomes (KDIGO) Glomerular Diseases Work Group. KDIGO 2021 Clinical Practice Guideline for the Management of Glomerular Diseases. Kidney Int. 2021 Oct;100(4S):S1-S276.
32. Chung SA, Langford CA, Maz M, Abril A, Gorelik M, Guyatt G, et al. 2021 American College of Rheumatology/Vasculitis Foundation Guideline for the Management of Antineutrophil Cytoplasmic Antibody-Associated Vasculitis. Arthritis Rheumatol. 2021 Aug;73(8):1366-1383.
33. Jayne DRW, Merkel PA, Schall TJ, Bekker P. Avacopan for the Treatment of ANCA-Associated Vasculitis. N Engl J Med. 2021 Feb 18;384(7):599-609.
34. Brugnara C, Berentsen S. Cold agglutinin disease. In: Mentzer WC, Brodsky RA (Ed). UpToDate [database on the internet]. Waltham (MA): UpToDate; 2022 [cited 2022 May 10]. Available from http://www.utdol.com/utd/index.do.
35. Syfovre™ [package insert]. Waltham (MA): Apellis Pharmaceuticals, Inc.; 2023 Feb.
36. FDA approves Syfovre as the first and only treatment for geographic atrophy, a leading cause of blindness. [press release on the internet]. Waltham (MA): Apellis Pharmaceuticals; 2023 February 17 [cited 2023 May 15]. Available from: https://investors.apellis.com/news-releases/news-release-details/fda-approves-syfovretm-pegcetacoplan-injection-first-and-only
37. American Academy of Ophthalmology. Age-Related Macular Degeneration Preferred Practice Pattern. Ophthalmology. 2019 Oct;127(1):1-65.
38. Lindblad AS, et al, and AREDS Research Group. Arch Ophthalmol. 2009;127(9):1168-1174
39. Apellis Pharmaceuticals. How Syfovre™ works [webpage on the internet]. Waltham (MA): Apellis pharmaceuticals; March 2023 [cited 2023 May 15]. Available from: https://syfovre.com/about-syfovre/how-syfovre-works/.
40. Vyvgart Hytrulo® [package insert on the internet]. Boston (MA): argenx US, Inc.; 2023 Jun.
41. Rystiggo® [package insert on the internet]. Smyrna (GA): UCB, Inc.; 2023.

Review History

02/08/2023 - Reviewed and created for Feb P&T; matched MH UPPL criteria to be in compliance with Masshealth unified formulary requirements. Effective 4/1/23
04/12/23 – Reviewed and updated for P&T. Added GPA/MPA to initial approval durations. Effective 6/5/23.
06/14/23 – Reviewed and updated for P&T. Removed preferred product requirement from Enjaymo, Uplizna, Soliris for requests reviewing under MB. Effective 6/30/23.
09/13/23 – Reviewed and updated for P&T. Enjaymo was updated and now requires members to have received a vaccine against encapsulated bacteria at least two weeks prior to treatment initiation. Due to the Medical Benefit Analysis, a decision was made to update Soliris (eculizumab), Vyvgart (efgartigimod alfa-fcab), Uplizna (inebilizumab-cdon) and Enjaymo (sutimlimab-jome) within this guideline to be managed through medical billing and designated with MB. Effective 10/2/23
2/14/24 – Reviewed and updated for P&T. Added Rystiggo and Vyvgart Hytrulo to policy requiring PA through MB (did not include preferred product requirement). Effective 3/4/24
04/10/24 – Reviewed and updated for P&T. Criteria added for Soliris for off label diagnosis of PLE/CHAPLE. New appendix “Age-Adjusted Serum IgG Concentration Reference Ranges” was created. **Syfovre** (pegcetacoplan 150 mg/mL vial) age criteria updated from ≥ 60 to ≥ 50 years of age. Effective 5/6/24