

## Ultomiris® (ravulizumab-cwvz) (Intravenous)

Document Number: IC-0427

Last Review Date: 06/06/2022

Date of Origin: 02/04/2019

Dates Reviewed: 02/2019, 10/2019, 12/2019, 11/2020, 07/2021, 10/2021, 06/2022

### I. Length of Authorization

Coverage will be provided for twelve (12) months and may be renewed.

### II. Dosing Limits

#### A. Quantity Limit (max daily dose) [NDC Unit]:

- Ultomiris 10 mg/mL\*\* – 30 mL SDV: 10 vials on day zero followed by 13 vials starting on day 14 and every 8 weeks thereafter
- Ultomiris 100 mg/mL – 3 mL SDV: 10 vials on day zero followed by 13 vials starting on day 14 and every 8 weeks thereafter
- Ultomiris 100 mg/mL – 11 mL SDV: 3 vials on day zero followed by 3 vials starting on day 14 and every 8 weeks thereafter

#### B. Max Units (per dose and over time) [HCPCS Unit]:

Indication	Loading Dose Units	Maintenance Dose Units
PNH/aHUS/gMG	300 units on Day 0	360 units on Day 14 and every 8 weeks thereafter

### III. Initial Approval Criteria <sup>1</sup>

Coverage is provided in the following conditions:

- Patient is at least 1 month of age (*unless otherwise specified*); **AND**
- Prescriber is enrolled in the Ultomiris Risk Evaluation and Mitigation Strategy (REMS) program; **AND**

#### Universal Criteria <sup>1</sup>

- Patients must be administered a meningococcal vaccine at least two weeks prior to initiation of therapy and will continue to be revaccinated according to current medical guidelines for vaccine use (*If urgent Ultomiris therapy is indicated in an unvaccinated patient, administer meningococcal vaccine(s) as soon as possible and provide patients with two weeks of antibacterial drug prophylaxis.*); **AND**

- Will not be used in combination with other immunomodulatory biologic therapies (i.e., efgartigimod, eculizumab, pegcetacoplan, satralizumab, inebilizumab, etc.); **AND**

### **Paroxysmal Nocturnal Hemoglobinuria (PNH) † ⊕ 1,4,8,9,18**

- Used as switch therapy; **AND**
  - Patient is currently receiving treatment with Soliris and has shown a beneficial disease response and absence of unacceptable toxicity while on therapy; **OR**
- Patient is complement inhibitor treatment-naïve; **AND**
  - Diagnosis must be accompanied by detection of PNH clones of at least 5% by flow cytometry diagnostic testing; **AND**
    - Demonstrate the presence of at least 2 different glycosylphosphatidylinositol (GPI) protein deficiencies (e.g., CD55, CD59, etc.) within at least 2 different cell lines (e.g., granulocytes, monocytes, erythrocytes); **AND**
    - Patient has laboratory evidence of significant intravascular hemolysis (i.e., LDH  $\geq 1.5 \times$  ULN) with symptomatic disease and at least one other indication for therapy from the following (regardless of transfusion dependence):
      - Patient has symptomatic anemia (i.e., hemoglobin  $< 7$  g/dL or hemoglobin  $< 10$  g/dL, in at least two independent measurements in a patient with cardiac symptoms)
      - Presence of a thrombotic event related to PNH
      - Presence of organ damage secondary to chronic hemolysis (i.e., renal insufficiency, pulmonary insufficiency/hypertension)
      - Patient is pregnant and potential benefit outweighs potential fetal risk
      - Patient has disabling fatigue
      - Patient has abdominal pain (requiring admission or opioid analgesia), dysphagia, or erectile dysfunction; **AND**
    - Documented baseline values for one or more of the following (necessary for renewal): serum lactate dehydrogenase (LDH), hemoglobin level, and packed RBC transfusion requirement, history of thrombotic events

### **Atypical Hemolytic Uremic Syndrome (aHUS) † 1,5,7**

- Used as switch therapy; **AND**
  - Patient is currently receiving treatment with Soliris and has shown a beneficial disease response and absence of unacceptable toxicity while on therapy; **OR**
- Patient is complement inhibitor treatment-naïve; **AND**
  - Patient shows signs of thrombotic microangiopathy (TMA) (e.g., changes in mental status, seizures, angina, dyspnea, thrombosis, increasing blood pressure, decreased platelet count, increased serum creatinine, increased LDH, etc.); **AND**

- Thrombotic Thrombocytopenic Purpura (TTP) has been ruled out by evaluating ADAMTS-13 level (ADAMTS-13 activity level  $\geq$  10%); **AND**
- Shiga toxin *E. coli* related hemolytic uremic syndrome (STEC-HUS) has been ruled out; **AND**
- Other causes have been ruled out such as coexisting diseases or conditions (e.g., bone marrow transplantation, solid organ transplantation, malignancy, autoimmune disorder, drug-induced, malignant hypertension, HIV infection, Streptococcus pneumoniae sepsis or known genetic defect in cobalamin C metabolism, etc); **AND**
- Documented baseline values for one or more of the following (necessary for renewal): serum lactate dehydrogenase (LDH), serum creatinine/eGFR, platelet count, and dialysis requirement

**Generalized Myasthenia Gravis (gMG) †  $\Phi$  1,11,12-17**

- Used as switch therapy; **AND**
  - Patient is at least 18 years of age; **AND**
  - Patient is currently receiving treatment with Soliris and has shown a beneficial disease response and absence of unacceptable toxicity while on therapy; **OR**
- Patient is complement inhibitor treatment-naïve; **AND**
  - Patient is at least 18 years of age; **AND**
  - Patient has Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of Class II to IV disease §; **AND**
  - Patient has a positive serologic test for anti-acetylcholine receptor (AChR) antibodies; **AND**
  - Patient has had a thymectomy (*Note: Applicable only to patients with thymomas OR non-thymomatous patients who are 50 years of age or younger*); **AND**
  - Physician has assessed objective signs of neurological weakness and fatiguability on a baseline neurological examination (e.g., including, but not limited to, the Quantitative Myasthenia Gravis (QMG) score, etc.); **AND**
  - Patient has a MG-Activities of Daily Living (MG-ADL) total score of  $\geq$ 6; **AND**
  - Patient will avoid or use with caution medications known to worsen or exacerbate symptoms of MG (e.g., certain antibiotics, beta-blockers, botulinum toxins, hydroxychloroquine, etc.); **AND**
  - Patient had an inadequate response after a minimum one-year trial with two (2) or more immunosuppressive therapies (e.g., corticosteroids plus an immunosuppressant such as azathioprine, cyclosporine, mycophenolate, etc.); **OR**
    - Patient required chronic treatment with plasmapheresis or plasma exchange (PE) or intravenous immunoglobulin (IVIG) in addition to immunosuppressant therapy

## § Myasthenia Gravis Foundation of America (MGFA) Disease Clinical Classification <sup>14</sup>:

- **Class I**: Any ocular muscle weakness; may have weakness of eye closure. All other muscle strength is normal.
- **Class II**: Mild weakness affecting muscles other than ocular muscles; may also have ocular muscle weakness of any severity.
  - **IIa**. Predominantly affecting limb, axial muscles, or both. May also have lesser involvement of oropharyngeal muscles.
  - **IIb**. Predominantly affecting oropharyngeal, respiratory muscles, or both. May also have lesser or equal involvement of limb, axial muscles, or both.
- **Class III**: Moderate weakness affecting muscles other than ocular muscles; may also have ocular muscle weakness of any severity.
  - **IIIa**. Predominantly affecting limb, axial muscles, or both. May also have lesser involvement of oropharyngeal muscles.
  - **IIIb**. Predominantly affecting oropharyngeal, respiratory muscles, or both. May also have lesser or equal involvement of limb, axial muscles, or both.
- **Class IV**: Severe weakness affecting muscles other than ocular muscles; may also have ocular muscle weakness of any severity.
  - **IVa**. Predominantly affecting limb, axial muscles, or both. May also have lesser involvement of oropharyngeal muscles.
  - **IVb**. Predominantly affecting oropharyngeal, respiratory muscles, or both. May also have lesser or equal involvement of limb, axial muscles, or both.
- **Class V**: Defined as intubation, with or without mechanical ventilation, except when employed during routine postoperative management. The use of a feeding tube without intubation places the patient in class IVb.

† FDA Approved Indication(s); ‡ Compendia Recommended Indication(s); Ⓢ Orphan Drug

## IV. Renewal Criteria <sup>1</sup>

Coverage may be renewed based upon the following criteria:

- Patient continues to meet the universal and other indication-specific relevant criteria identified in section III; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: serious meningococcal infections (septicemia and/or meningitis), infusion-related reactions, other serious infections, thrombotic microangiopathy (TMA) complications, etc.; **AND**

### Paroxysmal Nocturnal Hemoglobinuria (PNH) <sup>1,4,8,18</sup>

- Patient has not developed severe bone marrow failure syndrome (i.e., aplastic anemia or myelodysplastic syndrome) OR experienced a spontaneous disease remission OR received curative allogeneic stem cell transplant; **AND**
- Disease response indicated by one or more of the following:
  - Decrease in serum LDH from pretreatment baseline Stabilization/improvement in hemoglobin level from pretreatment baseline
  - Decrease in packed RBC transfusion requirement from pretreatment baseline (i.e., reduction of at least 30%)
  - Reduction in thromboembolic events

### Atypical Hemolytic Uremic Syndrome (aHUS) <sup>1,5,7</sup>

- Disease response indicated by one or more of the following:

- Decrease in serum LDH from pretreatment baseline
- Stabilization/improvement in serum creatinine/eGFR from pretreatment baseline
- Increase in platelet count from pretreatment baseline
- Decrease in plasma exchange/infusion requirement from pretreatment baseline

### Generalized Myasthenia Gravis (gMG)<sup>1,11-17</sup>

- Patient experienced an improvement (i.e., reduction) of at least 3-points from baseline in the Myasthenia Gravis-Specific Activities of Daily Living scale (MG-ADL) total score; **OR**
- Patient experienced an improvement of at least 5-points from baseline in the Quantitative Myasthenia Gravis (QMG) total score

### Switch therapy from Soliris to Ultomiris

- Refer to Section III for criteria

## V. Dosage/Administration <sup>1</sup>

Indication	Dose																																			
Paroxysmal nocturnal hemoglobinuria (PNH); Atypical Hemolytic Uremic Syndrome (aHUS); Generalized Myasthenia Gravis (gMG)	<b>Complement-Inhibitor Therapy Naïve*</b>																																			
	Administer the doses based on the patient's body weight. Starting 2 weeks after the loading dose, begin maintenance doses once every 4 weeks or every 8 weeks (depending on body weight)																																			
	<table border="1"> <thead> <tr> <th>Indications</th> <th>Body Weight Range</th> <th>Loading Dose (mg)</th> <th>Maintenance Dose (mg)</th> <th>Dosing Interval</th> </tr> </thead> <tbody> <tr> <td rowspan="4">PNH, aHUS</td> <td>≥5 kg - &lt;10 kg</td> <td>600</td> <td>300</td> <td>Every 4 weeks</td> </tr> <tr> <td>≥10 kg - &lt;20 kg</td> <td>600</td> <td>600</td> <td>Every 4 weeks</td> </tr> <tr> <td>≥20 kg - &lt;30</td> <td>900</td> <td>2,100</td> <td>Every 8 weeks</td> </tr> <tr> <td>≥30 kg - &lt;40 kg</td> <td>1,200</td> <td>2,700</td> <td>Every 8 weeks</td> </tr> <tr> <td rowspan="3">PNH, aHUS, gMG</td> <td>≥40 kg - &lt;60 kg</td> <td>2,400</td> <td>3,000</td> <td>Every 8 weeks</td> </tr> <tr> <td>≥60 kg - &lt;100 kg</td> <td>2,700</td> <td>3,300</td> <td>Every 8 weeks</td> </tr> <tr> <td>≥100 kg</td> <td>3,000</td> <td>3,600</td> <td>Every 8 weeks</td> </tr> </tbody> </table>	Indications	Body Weight Range	Loading Dose (mg)	Maintenance Dose (mg)	Dosing Interval	PNH, aHUS	≥5 kg - <10 kg	600	300	Every 4 weeks	≥10 kg - <20 kg	600	600	Every 4 weeks	≥20 kg - <30	900	2,100	Every 8 weeks	≥30 kg - <40 kg	1,200	2,700	Every 8 weeks	PNH, aHUS, gMG	≥40 kg - <60 kg	2,400	3,000	Every 8 weeks	≥60 kg - <100 kg	2,700	3,300	Every 8 weeks	≥100 kg	3,000	3,600	Every 8 weeks
	Indications	Body Weight Range	Loading Dose (mg)	Maintenance Dose (mg)	Dosing Interval																															
	PNH, aHUS	≥5 kg - <10 kg	600	300	Every 4 weeks																															
		≥10 kg - <20 kg	600	600	Every 4 weeks																															
		≥20 kg - <30	900	2,100	Every 8 weeks																															
		≥30 kg - <40 kg	1,200	2,700	Every 8 weeks																															
	PNH, aHUS, gMG	≥40 kg - <60 kg	2,400	3,000	Every 8 weeks																															
		≥60 kg - <100 kg	2,700	3,300	Every 8 weeks																															
≥100 kg		3,000	3,600	Every 8 weeks																																
<b>Switch Therapy from Eculizumab to Ultomiris*</b>																																				
For patients switching from eculizumab to Ultomiris, administer the loading dose of Ultomiris 2 weeks after the last eculizumab maintenance infusion (or 1 week after the last eculizumab induction infusion), and then administer Ultomiris maintenance doses once every 4 weeks or every 8 weeks depending on body weight, as shown in the table above), starting 2 weeks after loading dose administration.																																				
<i>*Note: For Supplemental Dose Therapy after plasma exchange (PE), plasmapheresis (PP), and intravenous immunoglobulin (IVIg), please refer to the package insert for appropriate dosing.</i>																																				

## VI. Billing Code/Availability Information

### HCPCS Code:

- J1303 – Injection, ravulizumab-cwvz, 10 mg; 1 billable unit = 10 mg

## NDC(s):

- Ultomiris 300 mg/3 mL single-dose vials for injection: 25682-0025-xx
- Ultomiris 300 mg/30 mL single-dose vials for injection: 25682-0022-xx\*\*
- Ultomiris 1100 mg/11 mL single-dose vials for injection: 25682-0028-xx

**\*\*Note:** This NDC has been discontinued as of 06/11/2021.

## VII. References

1. Ultomiris [package insert]. Boston, MA; Alexion Pharmaceuticals, Inc; April 2022. Accessed May 2022.
2. Guidelines for the diagnosis and monitoring of paroxysmal nocturnal hemoglobinuria and related disorders by flow cytometry. Borowitz MJ, Craig FE, DiGiuseppe JA, Illingworth AJ, Rosse W, Sutherland DR, Wittwer CT, Richards SJ. *Cytometry B Clin Cytom.* 2010 Jul;78(4):211-30. doi: 10.1002/cyto.b.20525.
3. Parker C, Omine M, Richards S, et al. Diagnosis and management of paroxysmal nocturnal hemoglobinuria. *Blood.* 2005 Dec 1. 106(12):3699-709.
4. Sahin F, Akay OM, Ayer M, et al. Pesg PNH diagnosis, follow-up and treatment guidelines. *Am J Blood Res.* 2016;6(2): 19-27.
5. Loirat C, Fakhouri F, Ariceta G, et al. An international consensus approach to the management of atypical hemolytic uremic syndrome in children. *Pediatr Nephrol.* 2016 Jan;31(1):15-39.
6. Taylor CM, Machin S, Wigmore SJ, et al. Clinical practice guidelines for the management of atypical haemolytic uraemic syndrome in the United Kingdom. *Br J Haematol.* 2010 Jan;148(1):37-47.
7. Cheong HI, Kyung Jo S, Yoon SS, et al. Clinical Practice Guidelines for the Management of Atypical Hemolytic Uremic Syndrome in Korea. *J Korean Med Sci.* 2016 Oct;31(10):1516-1528.
8. Brodsky RA, Peffault de Latour R, Rottinghaus ST, et al. Characterization of breakthrough hemolysis events observed in the phase 3 randomized studies of ravulizumab versus eculizumab in adults with paroxysmal nocturnal hemoglobinuria. *Haematologica.* 2020 Jan 16. pii: haematol.2019.236877. doi: 10.3324/haematol.2019.236877. [Epub ahead of print]
9. Patriquin CJ, Kiss T, Caplan S, et al. How we treat paroxysmal nocturnal hemoglobinuria: A consensus statement of the Canadian PNH Network and review of the national registry. *Eur J Haematol.* 2019;102(1):36. Epub 2018 Oct 25.
10. Lee H, Kang E, Kang HG, et al. Consensus regarding diagnosis and management of atypical hemolytic uremic syndrome. *Korean J Intern Med.* 2020;35(1):25-40. doi:10.3904/kjim.2019.388.
11. Sanders DB, Wolfe GI, Benatar M, et al. International consensus guidance for management of myasthenia gravis-Executive Summary. *Neurology.* 2016 Jul 26; 87(4): 419-25.
12. Vu T, Meisel A, Mantegazza R, et al. Efficacy and Safety of Ravulizumab, a Long-acting Terminal Complement Inhibitor, in Adults with Anti-Acetylcholine Receptor Antibody-

Positive Generalized Myasthenia Gravis: Results from the Phase 3 CHAMPION MG Study (P1-1.Virtual). Neurology May 2022, 98 (18 Supplement) 791.

13. Narayanaswami P, Sanders D, Wolfe G, Benatar M, et al. International consensus guidance for management of myasthenia gravis, 2020 update. Neurology® 2021;96:114-122. doi:10.1212/WNL.0000000000011124.
14. Jayam-Trouth A, Dabi A, Solieman N, Kurukumbi M, Kalyanam J. Myasthenia gravis: a review. Autoimmune Dis. 2012;2012:874680. doi:10.1155/2012/874680
15. Gronseth GS, Barohn R, Narayanaswami P. Practice advisory: Thymectomy for myasthenia gravis (practice parameter update): Report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology. Neurology. 2020;94(16):705. Epub 2020 Mar 25.
16. Sussman J, Farrugia ME, Maddison P, et al. Myasthenia gravis: Association of British Neurologists' management guidelines. Pract Neurol 2015; 15: 199-206.
17. Institute for Clinical and Economic Review. Eculizumab and Efgartigimod for the Treatment of Myasthenia Gravis: Effectiveness and Value. Draft evidence report. July 22, 2021. [https://icer.org/wp-content/uploads/2021/03/ICER\\_Myasthenia-Gravis\\_Draft-Evidence-Report\\_072221.pdf](https://icer.org/wp-content/uploads/2021/03/ICER_Myasthenia-Gravis_Draft-Evidence-Report_072221.pdf). Accessed December 22, 2021.
18. Cançado RD, Araújo AdS, Sandes AF, et al. Consensus statement for diagnosis and treatment of paroxysmal nocturnal haemoglobinuria. Hematology, Transfusion and Cell Therapy, v43, Iss3, 2021, 341-348. ISSN 2531-1379, <https://doi.org/10.1016/j.htct.2020.06.006>.

## Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
D59.3	Hemolytic-uremic syndrome
D59.5	Paroxysmal nocturnal hemoglobinuria [Marchiafava-Micheli]
G70.00	Myasthenia gravis without (acute) exacerbation
G70.01	Myasthenia gravis with (acute) exacerbation

## Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD), Local Coverage Articles (LCAs) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: <https://www.cms.gov/medicare-coverage-database/search.aspx>. Additional indications may be covered at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCA/LCD): N/A

### Medicare Part B Administrative Contractor (MAC) Jurisdictions

Jurisdiction	Applicable State/US Territory	Contractor
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA, LLC
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA, LLC
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC