CVS/specialty™

POLICY Document for SOLIRIS

The overall objective of this policy is to support the appropriate and cost effective use of the medication, lower cost site of care and overall clinically appropriate use. This document provides specific information to each section of the overall policy.

Section 1: Site of Care

- Policy information specific to site of care

Section 2: Enhanced Clinical Criteria

- Policy information specific to the clinical appropriateness for the medication

Section 1: Site of Care Policy

Site of Care Criteria
Administration of Soliris

I. CRITERIA FOR APPROVAL FOR ADMINISTRATION IN OUTPATIENT HOSPITAL SETTING

This policy provides coverage for administration of Soliris in an outpatient hospital setting for up to 2 doses (12 days) when a member is new to therapy.

This policy provides coverage for administration of Soliris in an outpatient hospital setting for a longer course of treatment when ANY of the following criteria are met:

A. The member has experienced a moderate or severe adverse reaction that did not respond to conventional interventions (eg, acetaminophen, steroids, diphenhydramine, fluids or other pre-medications).
B. The member is medically unstable (eg respiratory, cardiovascular, or renal conditions).
C. The member has severe venous access issues that require the use of a special intervention.
D. The member has a physical or cognitive impairment that would present unnecessary health risk.
E. Alternative infusion sites are not available.

For situations where administration of Soliris does not meet the criteria for outpatient hospital infusion, coverage for Soliris is provided when administered in alternative sites such as; physician office, home infusion or ambulatory care.

II. REQUIRED DOCUMENTATION

The following information is necessary to initiate the site of care prior authorization review (where applicable):

A. Medical records supporting the member has experienced a moderate or severe adverse reaction and did not respond to conventional interventions.
B. Medical records supporting the member is medically unstable.
C. Medical records supporting the member has severe venous access issues.
D. Medical records supporting the member has a physical or cognitive impairment.
E. Records supporting alternative infusion sites are not available.

CVS/specialty™

Section 2: Enhanced Clinical Criteria

SOLIRIS (eculizumab) ENHANCED SGM

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered covered benefits provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

1. Paroxysmal nocturnal hemoglobinuria (PNH) to reduce hemolysis
2. Atypical hemolytic uremic syndrome (aHUS) to inhibit complement-mediated thrombotic microangiopathy
3. Generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AchR) antibody positive
4. Neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive

Limitations of Use: Soliris is not indicated for the treatment of patients with Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS).

All other indications are considered experimental/investigational and are not covered benefits.

II. REQUIRED DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review for new requests for treatment of:

A. Atypical hemolytic uremic syndrome: ADAMTS 13 level
B. Paroxysmal nocturnal hemoglobinuria: flow cytometry used to show results of GPI-APs deficiency
C. Generalized myasthenia gravis: anti-acetylcholine receptor (AchR) antibody positive, clinical classification of myasthenia gravis score, MG activities of daily living score, use of IVIG and rituximab, use of two immunosuppressive therapies
D. Neuromyelitis optica spectrum disorder: immunoassay used to confirm anti-aquaporin-4 (AQP4) antibody is present

III. CRITERIA FOR INITIAL APPROVAL

A. Atypical hemolytic uremic syndrome

Authorization of 6 months may be granted for treatment of atypical hemolytic uremic syndrome not caused by Shiga toxin when all of the following criteria are met:

1. ADAMTS 13 activity level above 5%
2. Absence of Shiga toxin

B. Paroxysmal nocturnal hemoglobinuria

Authorization of 6 months may be granted for treatment of paroxysmal nocturnal hemoglobinuria (PNH) when all of the following criteria are met:

A. The diagnosis of PNH was confirmed by detecting a deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs) as demonstrated by either of the following:
   1. At least 5% PNH cells
   2. At least 51% of GPI-anchored protein deficient poly-morphonuclear cells
B. Flow cytometry is used to demonstrate GPI-anchored proteins deficiency

C. Generalized myasthenia gravis (gMG)

Authorization of 6 months may be granted for treatment of generalized myasthenia gravis (gMG) when all of the following criteria are met:

1. Anti-acetylcholine receptor (AchR) antibody positive
2. Myasthenia Gravis Foundation of America (MGFA) clinical classification II to IV
3. MG activities of daily living (MG-ADL) total score ≥6
4. Meets both of the following:
   a. Patient has had an inadequate response to at least two immunosuppressive therapies listed below:
      i. azathioprine
      ii. cyclosporine
      iii. mycophenolate mofetil
      iv. tacrolimus
      v. methotrexate
      vi. cyclophosphamide
   b. Member has inadequate response to chronic IVIG AND rituximab

D. Neuromyelitis Optica Spectrum Disorder (NMOSD)

Authorization of 6 months may be granted for treatment of neuromyelitis optica spectrum disorder (NMOSD) when all of the following criteria are met:

1. Anti-aquaporin-4 (AQP4) antibody positive
2. Member exhibits one of the following core clinical characteristics of NMOSD:
   a. Optic neuritis
   b. Acute myelitis
   c. Area postrema syndrome (episode of otherwise unexplained hiccups or nausea and vomiting)
   d. Acute brainstem syndrome
   e. Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions
   f. Symptomatic cerebral syndrome with NMOSD-typical brain lesions
3. The member will not be treated with rituximab and eculizumab concomitantly

IV. CONTINUATION OF THERAPY

A. Atypical hemolytic uremic syndrome

Authorization of 12 months may be granted to all members requesting continuation of therapy provided they meet all initial authorization criteria and demonstrate a positive response to therapy (e.g., normalization of lactate dehydrogenase (LDH) levels, platelet counts).

B. Paroxysmal nocturnal hemoglobinuria

Authorization of 12 months may be granted to all members requesting continuation of therapy provided they meet all initial authorization criteria and demonstrate a positive response to therapy (e.g., improvement in hemoglobin levels, normalization of LDH levels).

C. Generalized myasthenia gravis (gMG)
Authorization of 12 months may be granted to all members requesting continuation of therapy provided they meet all initial authorization criteria and demonstrate a positive response to therapy (e.g., improvement in MG-ADL scores, changes in baseline in Quantitative Myasthenia Gravis (QMG) total score).

D. Neuromyelitis optica spectrum disorder (NMOSD)
Authorization of 12 months may be granted to all members requesting continuation of therapy provided they meet all initial authorization criteria and demonstrate a positive response to therapy (e.g., reduction in number of relapses).

REFERENCES:

SECTION 1

1. Soliris [package insert]. New Haven, CT: Alexion Pharmaceuticals Inc; October 2017.

SECTION 2

1. Soliris [package insert]. New Haven, CT: Alexion Pharmaceuticals, Inc.; June 2019.
2. Loirat C, Fakhouri F, Ariceta G, et al. An international consensus approach to the management of atypical hemolytic uremic syndrome in children. *Pediatr Nephrol*. Published online: April 11, 2015.
3. Parker CJ. Management of paroxysmal nocturnal hemoglobulinuria in the era of complement inhibitory therapy. *Hematology.* 2011; 21-29.
4. Sanders D, Wolfe G, Benatar M et al. International consensus guidance for management of myasthenia gravis. *Neurology*. 2016; 87 (4):419-425.
5. Jaretzki A, Barohn RJ, Ernstoff RM et al. Myasthenia Gravis: Recommendations for Clinical Research Standards. *Ann Thorac Surg*. 2000;70: 327-34.
6. Hillmen P, Young NS, Schubert J, et al. The complement inhibitor eculizumab in paroxysmal nocturnal hemoglobinuria. *NEJM.* 2006;335:1233-43.
7. Howard JF, Utsugisawa K, Benatar M. Safety and efficacy of eculizumab in anti-acetylcholine receptor antibody-positive refractory generalized myasthenia gravis (REGAIN); a phase 3, randomized, double-blind, placebo-controlled, multicenter study. *Lancet Neurol*. 2017 Oct 20. http://dx.doi.org/10.1016/S1474-4422(17)30369-1Ingenix HCPCS Level II, Expert 2011.
8. 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(4):1840-1847.
9. Borowitz MJ, Craig F, DiGiuseppe JA, et al. Guidelines for the Diagnosis and Monitoring of Paroxysmal Nocturnal Hemoglobinuria and Related Disorders by Flow Cytometry. *Cytometry B Clin Cytom*. 2010: 78: 211-230.
10. Preis M, Lowrey CH. Laboratory tests for paroxysmal nocturnal hemoglobinuria (PNH). *Am J Hematol*. 2014;89(3):339-341.
11. Lee JW, Sicre de Fontbrune F, Wong LL, et al. Ravulizumab (ALXN1210) vs eculizumab in adult patients with PNH naive to complement inhibitors: The 301 study. *Blood*. 2018 Dec 3; pii: blood-2018-09-876136.
12. Pittock SJ, Berthele A, Kim HJ, et al. Eculizumab in Aquaporin-4-Positive Neuromyelitis Optica Spectrum Disorder. *N Engl J Med*. 2019 May 3. doi: 10.1056/NEJMoA1900866.
13. Wingerchuk DM, Banwell B, Bennett JL, et al. International consensus diagnostic criteria for neuromyelitis optica spectrum disorders. *Neurology.* 2015; 85:177-189.