Policy: MBP 54.0
Section: Medical Benefit Pharmaceutical Policy
Subject: Soliris (eculizumab)

I. Policy:
Soliris (eculizumab)

II. Purpose/Objective:
To provide a policy of coverage regarding Soliris (eculizumab)

III. Responsibility:
A. Medical Directors
B. Medical Management
C. Pharmacy Department

IV. Required Definitions
1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards good medical treatment practiced by the general medical community;
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

(i) the service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
(ii) the service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
(iii) the service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.
Soliris (eculizumab) is approved by the FDA for the treatment of paroxysmal nocturnal hemoglobinuria (PNH). Soliris works by blocking a part of the immune system called complement. By blocking complement, Soliris reduces the destruction of red blood cells and improves the symptoms of PNH.

CRITERIA FOR USE: Requires Prior Authorization by Medical Director or Designee

Soliris (eculizumab) will be considered medically necessary when all of the following criteria are met per indication:

1. **Paroxysmal Nocturnal Hemoglobinuria (PNH)**
   - Medical record documentation of a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)
   - Physician provided documentation of flow cytometry confirming diagnosis AND
   - Physician provided documentation of Soliris being prescribed by a hematologist AND
   - Physician provided documentation of the insured individual being vaccinated with the meningococcal vaccine AND
   - Physician documentation of one of the following:
     - member is transfusion-dependent (i.e., has at least 1 transfusion in the 24 months prior to initiation of eculizumab due to documented hemoglobin less than 7 g/dL in persons without anemic symptoms or less than 9 g/dL in persons with symptoms from anemia) prior to initiation of eculizumab treatment; or
     - there is a significant adverse impact on the insured individual’s health such as end organ damage or thrombosis without other cause.

   AUTHORIZATION DURATION: Approval will be given for six months. Additional coverage will only be provided when documentation of the following is provided:
   - Member requires fewer transfusions or has stabilization of Hb levels AND
   - Reduction in intravascular hemolysis as evidenced reduction in elevated LDH levels from baseline AND
   - No recurrent infections

2. **Atypical Hemolytic Uremic Syndrome (aHUS)**
   - Medical record documentation of a diagnosis of atypical hemolytic uremic syndrome (aHUS) *(Soliris is used to inhibit complement-mediated thrombotic microangiopathy)*

   AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

3. **Generalized Myasthenia Gravis (gMA)**
   - Medical record documentation supporting a confirmed diagnosis of Generalized Myasthenia Gravis AND
   - Medical record documentation that member is anti-acetylcholine receptor (AchR) antibody positive AND
   - Prescribed by or in consultation with a neuromuscular specialist AND
   - Medical record documentation of Myasthenia Gravis Foundation of America Clinical Classification (MGFA) Class II to IV AND *
   - Medical record documentation Myasthenia Gravis-Activities of Daily Living (MG-ADL) score of 6 or more at baseline AND**
   - Medical record documentation of age ≥ 18 years AND
   - Medical record documentation of therapeutic failure on, intolerance to, or contraindication to corticosteroids AND
   - Medical record documentation of therapeutic failure on, intolerance to, or contraindication to cholinesterase inhibitors AND
   - Medical record documentation of therapeutic failure on intolerance to, or contraindication to at least two (2) non-steroidal immunosuppressive therapies OR has failed at least one (1) immunosuppressive therapy and required chronic plasmapheresis or plasma exchange (PE) AND
   - Medical record documentation of failure on intolerance to, or contraindication to Rituxan AND
   - Medical record documentation of failure on intolerance to, or contraindication to intravenous immunoglobulin (IVIG)
**AUTHORIZATION DURATION**: Initial approval will be given for six months. Subsequent approvals will be for an additional six months and will require:
- Medical record documentation of continued disease improvement or lack of disease progression **AND**
- Medical record documentation that the member is responding positively to therapy as evidenced by a 3-point reduction in MG-ADL total score**;

The medication will no longer be covered if patient experiences toxicity or worsening of disease.

*Note: Class I Myasthenia gravis is indicated by any eye muscle weakness, possible ptosis (drooping or falling of the upper eyelid) and no other evidence of muscle weakness elsewhere. Class II to IV include muscle weakness in areas of the body beyond the eye.

Note: Corticosteroids: betamethasone, dexamethasone, methylprednisolone, prednisone
Cholinesterase inhibitors: pyridostigmine, neostigmine
Immunosuppressants: azathioprine, mycophenolate, cyclosporine, Rituxan

Note: Dosing for MG is 900 mg IV every 7 days for the first 4 weeks, followed by a single dose of 1,200 mg 7 days after the fourth dose, and then 1,200 mg every 2 weeks thereafter. Max dosage is 1,200 mg per dose.

### MG Activities of Daily Living (MG-ADL)**

<table>
<thead>
<tr>
<th>Grade</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talking</td>
<td>Normal</td>
<td>Intermittent slurring or nasal speech</td>
<td>Constant slurring or nasal, but can be understood</td>
<td>Difficult to understand speech</td>
<td></td>
</tr>
<tr>
<td>Chewing</td>
<td>Normal</td>
<td>Fatigue with solid food</td>
<td>Fatigue with soft food</td>
<td>Gastric tube</td>
<td></td>
</tr>
<tr>
<td>Swallowing</td>
<td>Normal</td>
<td>Rare episode of choking</td>
<td>Frequent choking necessitating changes in diet</td>
<td>Gastric tube</td>
<td></td>
</tr>
<tr>
<td>Breathing</td>
<td>Normal</td>
<td>Shortness of breath with exertion</td>
<td>Shortness of breath at rest</td>
<td>Ventilator dependence</td>
<td></td>
</tr>
<tr>
<td>Impairment of ability to brush teeth or comb hair</td>
<td>None</td>
<td>Extra effort, but no rest periods needed</td>
<td>Rest periods needed</td>
<td>Cannot do one of these functions</td>
<td></td>
</tr>
<tr>
<td>Impairment of ability to arise from a chair</td>
<td>None</td>
<td>Mild, sometimes uses arms</td>
<td>Moderate, always uses arms</td>
<td>Severe, requires assistance</td>
<td></td>
</tr>
<tr>
<td>Double vision</td>
<td>None</td>
<td>Occurs, but not daily</td>
<td>Daily, but not constant</td>
<td>Constant</td>
<td></td>
</tr>
<tr>
<td>Eyelid droop</td>
<td>None</td>
<td>Occurs, but not daily</td>
<td>Daily, but not constant</td>
<td>Constant</td>
<td></td>
</tr>
</tbody>
</table>

Total score _____________

4. **Neuromyelitis Optica Spectrum Disorder (NMOSD)**
- Prescribed by or in consultation with a neurologist
- Medical record documentation that member is 18 years or older **AND**
- Medical record documentation of diagnosis of Neuromyelitis Optica Spectrum Disorder (NMOSD) **AND**
- Medical record documentation that member is anti-Aquaporin-4 (AQP4) antibody positive **AND**
- Medical record documentation of failure on intolerance to, or contraindication to Rituxan.
AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

LINE OF BUSINESS:
Eligibility and contract specific benefit limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy.

This policy will be revised as necessary and reviewed no less than annually.

Devised: 7/11/07

Revised: 2/12 (criteria added); 2/13 (criteria revision), 1/20/15 (formatting changes), 3/22/17 (criteria updated, DHS), 3/20/18 (Myasthenia Gravis), 11/19/19 (NMOSD)

Reviewed: 10/09, 3/16, 1/31/17, 10/31/17, 2/26/19