

# PHARMACY POLICY STATEMENT

## Marketplace

|                     |                                     |
|---------------------|-------------------------------------|
| <b>DRUG NAME</b>    | <b>Ultomiris (ravulizumab-cwvz)</b> |
| <b>BENEFIT TYPE</b> | Medical, Pharmacy                   |
| <b>STATUS</b>       | Prior Authorization Required        |

Ultomiris was originally approved by the FDA in 2018 for the treatment of paroxysmal nocturnal hemoglobinuria (PNH). It is a terminal complement inhibitor that specifically binds to the complement protein C5 with high affinity, thereby inhibiting its cleavage to C5a (the proinflammatory anaphylatoxin) and C5b (the initiating subunit of the membrane attack complex [MAC or C5b-9]) thus preventing MAC formation.

Ultomiris was engineered from an earlier product, Soliris, to have a longer half-life allowing for extended dosing intervals (every 2 weeks vs. every 8 weeks). Ultomiris and Soliris are virtually identical aside from Ultomiris having the longer half-life.

Ultomiris is also approved for the treatment of atypical hemolytic uremic syndrome (aHUS) to inhibit complement-mediated thrombotic microangiopathy (TMA), for the treatment of anti-acetylcholine receptor (AChR) antibody-positive generalized myasthenia gravis (gMG), and for anti-aquaporin-4 (AQP4) antibody positive neuromyelitis optica spectrum disorder (NMOSD).

Ultomiris (ravulizumab-cwvz) will be considered for coverage when the following criteria are met:

### Atypical Hemolytic Uremic Syndrome (aHUS)

For **initial** authorization:

1. Medication is prescribed by or in consultation with a hematologist or nephrologist; AND
2. Member has a diagnosis of aHUS supported by ALL of the following:
  - a) Thrombocytopenia (platelet count  $< 150 \times 10^9/L$ )
  - b) Evidence of microangiopathic hemolytic anemia (MAHA) e.g., hemoglobin  $< 10$  g/dL, elevated lactate dehydrogenase (LDH), low haptoglobin, presence of fragmented red blood cells or schistocytes on blood smear
  - c) Evidence of renal impairment (e.g., raised SCr or low eGFR); AND
3. Shiga toxin-producing E. coli related HUS (STEC-HUS) has been ruled out; AND
4. ADAMTS13 activity level is  $> 10\%$  (to rule out TTP); AND
5. Member has received meningococcal vaccine.
6. **Dosage allowed/Quantity limit:**

IV infusion: loading dose followed by maintenance doses starting 2 weeks later, based on body weight, per prescribing information. See appendix 1.

Subcutaneous (adults only): 490 mg once weekly (8 cartons per 28 days)

***If all the above requirements are met, the medication will be approved for 6 months.***

For **reauthorization**:

1. Chart notes must demonstrate hematologic normalization as evidenced by increased platelet count or LDH maintained below upper limit of normal; AND
2. Improved or preserved kidney function.

***If all the above requirements are met, the medication will be approved for an additional 12 months.***

## Paroxysmal Nocturnal Hemoglobinuria (PNH)

For **initial** authorization:

1. Medication is prescribed by or in consultation with a hematologist; AND
2. Member has a documented diagnosis of PNH as confirmed by flow cytometry; AND
3. Member has a lactate dehydrogenase (LDH) level  $>1.5\times$  upper limit of normal (ULN); AND
4. Member has at least one PNH-related sign/symptom e.g., fatigue, hemoglobin  $<10$  g/dL, thrombosis, pRBC transfusion, shortness of breath; AND
5. Member has received meningococcal vaccine.
6. **Dosage allowed/Quantity limit:**  
IV infusion: loading dose followed by maintenance doses starting 2 weeks later, based on body weight, per prescribing information. See appendix 1.  
Subcutaneous (adults only): 490 mg once weekly (8 cartons per 28 days).

***If all the above requirements are met, the medication will be approved for 6 months.***

For **reauthorization**:

1. Clinical evidence of positive response to therapy such as increased hemoglobin level, decreased need for transfusions, normalized LDH levels, improved fatigue.

***If all the above requirements are met, the medication will be approved for an additional 12 months.***

## Generalized Myasthenia Gravis (gMG)

For **initial** authorization:

1. Member is at least 18 years of age; AND
2. Medication is prescribed by or in consultation with a neurologist; AND
3. Member has a documented diagnosis of MGFA class II-IV myasthenia gravis (see appendix 2); AND
4. Lab result in chart notes shows the member is seropositive for AChR antibodies; AND
5. Member has tried and failed at least 1 conventional therapy:
  - a) Pyridostigmine
  - b) Corticosteroid for at least 4 weeks
  - c) Non-steroid immunosuppressant (e.g., azathioprine) for at least 6 months; AND
6. Member has tried and failed IV Vyvgart; AND
7. Member has received meningococcal vaccine.
8. **Dosage allowed/Quantity limit:** Administered by IV infusion; loading dose followed by maintenance doses starting 2 weeks later, based on body weight, per prescribing information. See appendix 1.

***If all the above requirements are met, the medication will be approved for 6 months.***

For **reauthorization**:

1. Chart notes must document clinically meaningful improvement in symptom severity and daily functioning compared to pre-treatment baseline (e.g., improved MG-ADL or QMG scores).

***If all the above requirements are met, the medication will be approved for an additional 12 months.***

## Neuromyelitis Optica Spectrum Disorder (NMOSD)

For **initial** authorization:

1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with a neurologist; AND
3. Member has a documented diagnosis of NMOSD and is seropositive for aquaporin-4 (AQP4) IgG antibodies; AND
4. Member had had 1 or more relapses within the past year; AND

5. Member has tried and failed rituximab for at least 6 months (requires prior auth); AND
6. Member has received meningococcal vaccine.
7. **Dosage allowed/Quantity limit:** Administered by IV infusion; loading dose followed by maintenance doses starting 2 weeks later, based on body weight, per prescribing information. See appendix 1.

***If all the above requirements are met, the medication will be approved for 6 months.***

For **reauthorization**:

1. Chart notes must document disease stabilization, symptom improvement, and/or reduced frequency of relapses.

***If all the above requirements are met, the medication will be approved for an additional 12 months.***

**CareSource considers Ultomiris (ravulizumab-cwvz) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.**

| DATE       | ACTION/DESCRIPTION                                                                                                                                                                                                                                                                                                                                                                                                                   |
|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 05/07/2019 | New policy for Ultomiris created.                                                                                                                                                                                                                                                                                                                                                                                                    |
| 10/26/2019 | New diagnosis of aHUS added.                                                                                                                                                                                                                                                                                                                                                                                                         |
| 06/03/2021 | aHUS: Updated references. Added specialist requirement. Revised diagnostic parameters. Summarized excluded causes. Removed list of restrictions from clinical trials. Revised renewal criteria.<br>PNH: Updated references. Removed nephrology as specialist. Removed transfusion and organ damage requirements. Updated dosing information. Reduced initial approval duration from 12 months to 6 months. Revised renewal criteria. |
| 05/19/2022 | Diagnosis of myasthenia gravis added.                                                                                                                                                                                                                                                                                                                                                                                                |
| 08/12/2022 | Added dosing for new subQ product (adults with PNH or aHUS only); added pharmacy benefit.                                                                                                                                                                                                                                                                                                                                            |
| 07/19/2023 | gMG: Added reference. Split list of conventional drug trials. Added trial of Vyvgart IV.<br>aHUS: Updated and added references. Corrected ADAMTS13 level cutoff. Changed "evidence of hemolysis" to evidence of MAHA.<br>PNH: Added reference. Added that they must be symptomatic.                                                                                                                                                  |
| 04/04/2024 | Added criteria section for new indication of NMOSD.                                                                                                                                                                                                                                                                                                                                                                                  |
| 05/19/2025 | MG: Changed steroid trial duration from 3 months to 4 weeks (Sanders, Alhaidar).                                                                                                                                                                                                                                                                                                                                                     |

APPENDIX 1:

**Table 1: ULTOMIRIS Vial for Intravenous (IV) Administration Weight-Based Dosing Regimen – PNH, aHUS, gMG, or NMOSD\***

| Indications              | Body Weight Range (kg) | Loading Dose (mg)** | Maintenance Dose (mg) and Dosing Interval |               |
|--------------------------|------------------------|---------------------|-------------------------------------------|---------------|
| PNH or aHUS              | 5 to less than 10      | 600                 | 300                                       | Every 4 weeks |
|                          | 10 to less than 20     | 600                 | 600                                       |               |
|                          | 20 to less than 30     | 900                 | 2,100                                     | Every 8 weeks |
|                          | 30 to less than 40     | 1,200               | 2,700                                     |               |
| PNH, aHUS, gMG, or NMOSD | 40 to less than 60     | 2,400               | 3,000                                     | Every 8 weeks |
|                          | 60 to less than 100    | 2,700               | 3,300                                     |               |
|                          | 100 or greater         | 3,000               | 3,600                                     |               |

## APPENDIX 2:

| MG Foundation of America (MGFA) Clinical Classification |                                                                                                   |
|---------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| Class I                                                 | any ocular weakness; all other muscle strength is normal                                          |
| Class II                                                | mild weakness affecting other than ocular muscles; may also have ocular weakness at any level     |
| Class III                                               | moderate weakness affecting other than ocular muscles; may also have ocular weakness at any level |
| Class IV                                                | severe weakness affecting other than ocular muscles; may also have ocular weakness at any level   |
| Class V                                                 | defined by intubation, with or without mechanical ventilation                                     |

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Effective date: 10/01/2025

Revised date: 05/19/2025