Medical Policy

Empaveli™ (pegcetacoplan)	
MEDICAL POLICY NUMBER	Med_Clin_Ops_076
CURRENT VERSION EFFECTIVE DATE	January 1, 2024
APPLICABLE PRODUCT AND MARKET	*Individual Family Plan:* All Plans *Small Group*: All Plans *Medicare Advantage:* All Plans

Brand New Day/Central Health Medicare Plan develops policies and makes coverage determinations using credible scientific evidence including but not limited to MCG™ Health Guidelines, the ASAM Criteria™, and other third party sources, such as peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and expert opinion as relevant to supplement those sources. Brand New Day/Central Health Medicare Plan Medical Policies, MCG™ Guidelines, and the ASAM Criteria™ are not intended to be used without the independent clinical judgment of a qualified health care provider considering the individual circumstances of each member's case. The treating health care providers are solely responsible for diagnosis, treatment, and medical advice. Members may contact Brand New Day/Central Health Medicare Plan Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Brand New Day/Central Health Medicare Plan Medical Policy may contact the Health Plan. Brand New Day/Central Health Medicare Plan policies and practices are compliant with federal and state requirements, including mental health parity laws.

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PURPOSE

To promote consistency between reviewers in clinical coverage decision-making by providing the criteria that generally determine the medical necessity of Empaveli™ (pegcetacoplan) therapy.

POLICY/CRITERIA

Prior Authorization and Medical Review is required.

Coverage for Empaveli will be provided for 12 months and may be renewed

Initial Therapy

1. Patient is 18 years of age or older; **AND**
2. Empaveli is being prescribed by or in consultation with a hematologist, oncologist or immunology specialist; **AND**
3. Prescriber has enrolled in the Empaveli REMS program and ensures patients are vaccinated against encapsulated bacteria; **AND**

4. Patient has a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) confirmed by peripheral blood flow cytometry results showing the presence of at least 2 different glycosylphosphatidylinositol (GPI) protein deficiencies (e.g. CD55, CD59, etc.) within at least 2 different cell lines (granulocytes, monocytes, erythrocytes); **AND**
5. Patient has one of the following indications for therapy:
    a. Patient has an LDH level of 1.5 times the upper limit of the normal range with clinical symptoms; **OR**
    b. Patient is transfusion dependent as defined by one of the following:
        i. Hemoglobin < 7 g/dL; **OR**
        ii. Hemoglobin < 9 g/dL **AND** patient is experiencing symptoms of anemia; **OR**
    c. Patient has symptoms of thromboembolic complications (abdominal pain, shortness of breath, chest pain, end organ damage; **OR**
    d. Patient presents with organ damage secondary to chronic hemlysis; **AND**
6. Patient is vaccinated against encapsulated bacteria, including *Streptococcus pneumoniae*, *Neisseria meningitidis*, and *Haemophilus influenzae* type B, according to the most current Advisory Committee on Immunization Practices (ACIP) recommendations at least 2 weeks prior to administering the first dose of Empaveli; **AND**
7. Patient will be provided two (2) weeks of antibacterial drug prophylaxis if Empaveli must be initiated immediately.

Continuation Therapy

1. Patient has demonstrated a positive clinical response from baseline (e.g., stabilization of hemoglobin levels, decreased transfusion requirements or transfusion independence, reductions in hemolysis) from Empaveli, according to the prescribing physician; AND
2. Patient will be revaccinated in accordance with ACIP recommendations considering the duration of therapy with Empaveli.

LIMITATIONS/EXCLUSIONS

1. Any indication other than those listed above due to insufficient evidence of therapeutic value
2. Patients who are not currently vaccinated against certain encapsulated bacteria unless the risks of delaying EMPAVELI treatment outweigh the risks of developing a bacterial infection with an encapsulated organism.
3. Patients with unresolved serious infection caused by encapsulated bacteria including *Streptococcus pneumoniae*, *Neisseria meningitidis*, and *Haemophilus influenzae*.

BACKGROUND

EMPAVELI™ is indicated for the treatment of adult patients with paroxysmal nocturnal hemoglobinuria (PNH).

Pegcetacoplan binds to complement protein C3 and its activation fragment C3b, thereby regulating the cleavage of C3 and the generation of downstream effectors of complement

activation. In PNH, extravascular hemolysis (EVH) is facilitated by C3b opsonization while intravascular hemolysis (IVH) is mediated by the downstream membrane attack complex (MAC). Pegcetacoplan acts proximally in the complement cascade controlling both C3b-mediated EVH and terminal complement-mediated IVH.

DEFINITIONS

1. EMPAVELI™ (pegcetacoplan) injection, for subcutaneous use. Initial U.S. Approval: 2021
    a. EMPAVELI injection is a clear, colorless to slightly yellowish aqueous solution for subcutaneous infusion supplied as 1,080 mg/20 mL (54 mg/mL) solution in 20-mL single-dose vials.
    b. EMPAVELI is available in 20-mL single-dose vials individually packaged in cartons that are supplied in 8-count convenience cartons. NDC 73606-010-01.

CODING

Applicable NDC Codes	
73606-0010-01	Empaveli (pegcetacoplan) 54 mg/1 ml injection per vial

Applicable Procedure Code	
C9399	Unclassified drugs or biologics (When utilized for Empaveli [pegcetacoplan])
J3490	Unclassified drugs (When utilized for Empaveli [pegcetacoplan])
J3590	Unclassified biologics (When utilized for Empaveli [pegcetacoplan])

Applicable ICD-10 Codes	
D59.5	Paroxysmal nocturnal hemoglobinuria

EVIDENCE BASED REFERENCES

1. Product Information: EMPAVELI(TM) subcutaneous solution, pegcetacoplan subcutaneous solution. Apellis Pharmaceuticals Inc (per manufacturer), Waltham, MA, 2021.

POLICY HISTORY

Approved by Pharmacy and Therapeutics Committee

Original Effective Date	July 19, 2021
Revised	November 1, 2021 November 8, 2022 – Annual Review and approval (no policy revisions made) March 1, 2023 – Adopted by MA UMC (no changes) January 1, 2024 - Updated to Brand New Day/Central Health Medicare Plan (no policy revisions made)

Approved by Pharmacy and Therapeutics Committee on 11/8/2022