Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines
Medical Benefit Drugs
Complement Inhibitors

Effective: January 1, 2026

Guideline Type	☒ Prior Authorization ☐ Non-Formulary ☐ Step-Therapy ☐ Administrative

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; Fax 617-673-0988

☒ Tufts Health Plan Commercial products; Fax 617-673-0988

CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax 617-673-0988

☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax 617-673-0939

☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax 617-673-0939

☐ Tufts Health One Care* – A Medicare-Medicaid Plan (a dual eligible product); Fax 617-673-0956

*The MNG applies to Tufts Health One Care members unless a less restrictive LCD or NCD exists.

Senior Products

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); Fax 617-673-0956

☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); Fax 617-673-0956

☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); Fax 617-673-0956

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Food and Drug Administration-Approved Indications

Empaveli (pegcetacoplan) is a complement inhibitor indicated for the treatment of:

- **Paroxysmal Nocturnal Hemoglobinuria (PNH)**
  Adults with PNH
  - **C3 glomerulopathy or primary immune-complex membranoproliferative glomerulonephritis**
  Adults and pediatric patients aged 12 years and older with C3 glomerulopathy (C3G) or primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN), to reduce proteinuria

PiaSky (crovalimab-akkz) is a complement inhibitor indicated for the treatment of:

- **Paroxysmal Nocturnal Hemoglobinuria (PNH)**
  Adults and pediatric patients 13 years of age and older with PNH and body weight of at least 40 kg

Soliris (eculizumab) is a complement inhibitor indicated for the treatment of:

- **Atypical Hemolytic Uremic Syndrome (aHUS)**
  Patients with aHUS to inhibit complement-mediated thrombotic microangiopathy
- **Generalized Myasthenia Gravis (gMG)**
  Adult and pediatric patients six years of age and older with gMG who are anti-acetylcholine receptor antibody positive
- **Neuromyelitis Optica Spectrum Disorder (NMOSD)**
  NMOSD in adult patients who are anti-aquaporin-4 antibody positive
- **Paroxysmal Nocturnal Hemoglobinuria (PNH)**
  Patients with PNH to reduce hemolysis

Ultomiris (ravulizumab-cwvz) is a complement inhibitor indicated for the treatment of:

- **Atypical Hemolytic Uremic Syndrome (aHUS)**
  Adults and pediatric patients one month of age and older with aHUS to inhibit complement- mediated

thrombotic microangiopathy (TMA)

- **Paroxysmal Nocturnal Hemoglobinuria (PNH)**
  Adults and pediatric patients one month of age and older with paroxysmal nocturnal hemoglobinuria
- **Generalized Myasthenia Gravis**
  Adult patients with generalized myasthenia gravis (gMG) who are anti-acetylcholine receptor (AChR) antibody-positive
- **Neuromyelitis Optica Spectrum Disorder (NMOSD)**
  NMOSD in adult patients who are anti-aquaporin-4 antibody positive

Clinical Guideline Coverage Criteria

Atypical Hemolytic Uremic Syndrome (aHUS)

The plan may authorize coverage of Soliris or Ultomiris for Members when **ALL** of the following clinical criteria are met:

1. Documented diagnosis of atypical hemolytic uremic syndrome

AND

2. The prescribing physician is a hematologist or nephrologist

Generalized Myasthenia Gravis (gMG)

The plan may authorize coverage of Soliris or Ultomiris for Members when **ALL** of the following criteria are met:

Initial Authorization Criteria

1. Documented diagnosis of generalized myasthenia gravis

AND

2. Documentation of a positive serologic test for anti-acetylcholine antibodies

AND

3. Documentation of Myasthenia Gravis Foundation of America (MGFA) Clinical Classification Class II to IV generalized myasthenia gravis

AND

4. Documentation of a Myasthenia Gravis-Activities of Daily Living (MG-ADL) total score ≥6

AND

5. The prescribing physician is a neurologist

AND

6. Documentation of at least **one (1)** of the following:
   a. Persistent symptoms that limit function following a previous trial of immunosuppressive therapy consisting of a glucocorticoid in combination with at least one other immunotherapeutic agent (e.g., azathioprine, mycophenolate, cyclosporine, tacrolimus)
   b. Ongoing rescue therapy with intravenous immunoglobulin or plasma exchange while receiving immunosuppressive therapy
   c. Clinical rationale to avoid immunosuppressive therapy with glucocorticoids and other immunotherapeutic agents (e.g., azathioprine, mycophenolate, cyclosporine, tacrolimus)

AND

7. If the requested medication is Soliris, documentation that the Member has demonstrated an inadequate response to Ultomiris or the provider has indicated clinical inappropriateness of treatment with Ultomiris

Reauthorization Criteria

1. Documented diagnosis of generalized myasthenia gravis

AND

2. Documentation of a positive serologic test for anti-acetylcholine antibodies

AND

3. The prescribing physician is a neurologist

AND

4. Documentation the Member has experienced a therapeutic response as defined by a decrease in the Myasthenia Gravis-Activities of Daily Living (MG-ADL) total score from baseline

Paroxysmal Nocturnal Hemoglobinuria (PNH)

The plan may authorize coverage of Empaveli, PiaSky, Soliris, or Ultomiris for Members when **ALL** of the following criteria are met:

Initial Authorization Criteria

1. Documented diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)

AND

2. Documentation that paroxysmal nocturnal hemoglobinuria is confirmed by detecting a deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs) as demonstrated by **either** of the following:
    a. At least 5% PNH cells
    b. At least 51% of GPI-AP deficient poly-morphonuclear cells

AND

3. Flow cytometry is used to demonstrate GPI-APs deficiency

Reauthorization Criteria

1. Documented diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)

AND

2. Documentation the Member has experienced a therapeutic response as defined by **one (1)** ofthe following:
    a. Improvement in hemoglobin levels
    b. Normalization of lactate dehydrogenase levels

Neuromyelitis Optica Spectrum Disorder (NMOSD)

The plan may authorize coverage of Soliris or Ultomiris for Members when **ALL** of the following criteria are met:

1. Documented diagnosis of neuromyelitis optica spectrum disorder

AND

2. Documentation of a positive serologic test for anti-aquaporin-4 antibodies

AND

3. The prescribing physician is a neurologist or an ophthalmologist

C3 glomerulopathy or primary immune-complex membranoproliferative glomerulonephritis

The plan may authorize coverage of Empaveli for Members when **ALL** of the following criteria are met:

Initial Authorization Criteria

1. Documented diagnosis of C3 glomerulopathy (C3G) or primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN)

AND

2. Member is 12 years of age or older

Reauthorization Criteria

1. Documented diagnosis of C3 glomerulopathy (C3G) or primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN)

AND

2. *Documentation* the Member has experienced a therapeutic response as defined by a reduction in proteinuria

Limitations

- Initial approval of Complement Inhibitors will be authorized for six (6) months for the diagnoses of generalized myasthenia gravis,paroxysmal nocturnal hemoglobinuria, and C3 glomerulopathy (C3G) or primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN). Reauthorization of Complement Inhibitors will be provided in 12-month intervals.
- Members new to the plan stable on a Complement Inhibitor for the treatment of generalized myasthenia gravis,paroxysmal nocturnal hemoglobinuria, or C3 glomerulopathy (C3G) or primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN) should be reviewed against Reauthorization Criteria.
- Coverage will not be authorized if the Member is receiving combination complement inhibitor therapy.

Codes

The following code(s) require prior authorization:

Table 1: HCPCS Codes

HCPCS Codes	Description
J1299	Injection, eculizumab, 2 mg
J1303	Injection, ravulizumab-cwvz, 10 mg
J1307	Injection, crovalimab-akkz, 10 mg

References

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4. Empaveli (pegcetacoplan) [package insert]. Waltham, MA: Apellis Pharmaceuticals, Inc. July 2025.
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Approval And Revision History

September 13, 2022: Reviewed by Pharmacy and Therapeutics Committee (P&T)

Subsequent endorsement date(s) and changes made:

- September 21, 2022: Reviewed by the Medical Policy Approval Committee (MPAC)
- Originally approved September 13, 2022 by P&T and September 21, 2022 by MPAC committees effective January 1, 2023
- Administrative update: June 2023 added Medical Benefit Drugs to title and updated MATogether and RITogether fax numbers to 617-673-0939
- Coding update per HCPCS level II quarterly release. Effective date July 1, 2023, the following HCPCS codes have been added: C9151
- September 12, 2023: Minor wording updates throughout Medical Necessity Guideline to clarify coverage. Removed the Limitations “For the treatment of NMOSD, combination therapy with Uplizna will not be authorized.” And “Complement inhibitors will not be approved for other types of hemolytic uremic syndrome including STEC-HUS.” Clarified duration of coverage rules (effective 10/1/23).
- December 2023: Administrative update to rebrand Tufts Health Unify to Tufts Health One Care for 2024.
- August 13, 2024: Updated requirements to establish refractory disease of generalized myasthenia gravis. Added Ultomiris to existing coverage criteria for NMSOD based on the supplemental indication (eff 1/1/25).
- September 10, 2024: Updated requirements to establish refractory disease of generalized myasthenia gravis (eff 1/1/25).
- October 8, 2024: For NMOSD, removed “Documentation that the Member has demonstrated an inadequate response to Uplizna, or the provider has indicated that Uplizna is not clinically appropriate for the Member” (eff 1/1/25).
- December 10, 2024: Added PiaSky to the Medical Necessity Guideline. Administrative update to remove HCPCS code C9151; included in error. (eff 1/1/25).
- March 11, 2025: Administrative update to remove J Code, J1300 and adding J Code, J1299 (effective 4/1/25).
- December 9, 2025: Updated overview section to include Soliris’s expanded indication for Generalized Myasthenia Gravis (gMG) from adults to Adult and pediatric patients six years of age and older. Updated overview section to include Empaveli’s newly approved indication of C3 glomerulopathy (C3G) or primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN) in adults and pediatric patients aged 12 years and older (effective 1/1/26).

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.

Provider Services