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

Public Plans Products

☒ 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

Myasthenia gravis (MG) is an autoimmune disorder characterized by muscle weakness and fatigue. There are two classifications of MG: ocular and general. The degree of muscle weakness can fluctuate and vary in severity from person to person; however, it will generally improve with rest and worsen with physical activity. Most patients with MG develop autoantibodies that attack the acetylcholine receptor (AChR), blocking or destroying the receptors, which prevents muscles from contracting. Treatment decisions for generalized myasthenia gravis (gMG) are based on knowledge of the natural history of disease in each patient and the predicted response to a specific form of therapy. Goals are individualized based on disease severity, patient age and sex, and the degree of functional impairment. Evidence to support the use of Soliris in refractory or severe disease comes from the Phase 3 REGAIN trial in which patients who had failed at least two immunosuppressive therapies were included. Efficacy was established based on the impact to Myasthenia Gravis Activities of Daily Living (MG-ADL) score after 26 weeks. Furthermore, clinical benefit appeared to occur rapidly in patients who did respond to treatment with Soliris. Approval of Ultomiris for MG was based on a trial in which patients with MG with a positive serologic test for anti-AChR antibodies treated with Ultomiris achieved a statistically significant change in the MG-ADL and Quantitative MG total scores from baseline at Week 26 compared to placebo.

Neuromyelitis optica spectrum disorder (NMOSD) is an ultra-rare autoimmune disease resulting from inflammation of the central nervous system that is characterized by severe demyelination and axonal damage, predominantly targeting the optic nerves and spinal cord. Patients frequently experience a relapsing disease course. Neurologic damage and disability accumulate with repeated attacks. Approval of Soliris for treatment of NMOSD in anti-AQP4 antibody positive patients was based on the PREVENT trial. Results demonstrated that the time to the first relapse was significantly longer in Soliris-treated patients compared to placebo-treated patients, with or without concomitant treatment. Furthermore, Soliris-treated patients had reduced annualized rates of hospitalizations, of corticosteroid administrations to treat acute relapses, and of plasma exchange treatments. The approval of Ultomiris for NMOSD was based on positive results from the Phase III CHAMPION-NMOSD trial where Ultomiris was compared to an external placebo arm from the pivotal Soliris PREVENT clinical trial. Ultomiris met the primary endpoint of time to first on-trial relapse. Zero relapses were observed among Ultomiris-treated patients with a median treatment duration of 73 weeks.

Additional coverage for Soliris (eculizumab) is also supported by the Local Coverage Determination (LCD) Drugs and Biologicals, Coverage of, for Label and Off-Label Uses (L33394).

The approval of Empaveli for C3G and IC-MPGN was based on results from the Phase 3 VALIANT trial, in which Empaveli demonstrated a 68% reduction in proteinuria at 26 weeks versus placebo. Empaveli also stabilized kidney function and achieved substantial clearance of C3 deposits as measured by C3 staining

Food and Drug Administration-Approved Indications

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

- Adult patients with paroxysmal nocturnal hemoglobinuria (PNH).
- C3 glomerulopathy (C3G) or primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN) in patients ≥12 years of age, 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 patients 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)**
  Patients with aHUS to inhibit complement-mediated thrombotic microangiopathy
- **Generalized Myasthenia Gravis (gMG)**
  Adult patients 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

Clinical Guideline Coverage Criteria

Atypical Hemolytic Uremic Syndrome

The plan may authorize coverage of Soliris or Ultomiris for Members when documentation of the following criteria is met:

1. Documented diagnosis of atypical hemolytic uremic syndrome (aHUS)

Paroxysmal Nocturnal Hemoglobinuria

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

1. Documented diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)

Biopsy Proven Dense Deposit Disease

The plan may authorize coverage of Soliris for Members when documentation of the following criteria is met:

1. Documented diagnosis of biopsy proven dense deposit disease

Generalized Myasthenia Gravis

The plan may authorize coverage of Soliris or Ultomiris for Members when documentation of the following criteria is 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. The prescribing physician is a neurologist

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 an improvement of Myasthenia Gravis-Activities of Daily Living (MG-ADL) total score from baseline

Neuromyelitis Optica Spectrum Disorder (NMOSD)

The plan may authorize coverage of Soliris or Ultomiris for Members when documentation of the following criteria is met:

1. Documented diagnosis of neuromyelitis optica spectrum disorder

AND

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

C3 Glomerulopathy and IC-MPGN

The plan may authorize coverage of Empaveli for Members when documentation of the following criteria is met:

1. Documented diagnosis of biopsy-confirmed primary C3G or primary IC-MPGN
2. Evidence of active disease: UPCR ≥1 g/g and eGFR ≥30 mL/min/1.73 m2
3. Evidence of optimized optimized antiproteinuric regimen (e.g. ACEi/ARBs ± SGLT2is)

Limitations

- Refer to the Medicare Part B Step Therapy Medical Necessity Guideline for additional requirements.
  - Initial coverage of a Complement Inhibitor for generalized myasthenia gravis will be authorized for 6 months. Reauthorization of a Complement Inhibitor will be provided for 12-month intervals.
- Members new to the plan stable on a Complement Inhibitor should be reviewed against Reauthorization Criteria for generalized myasthenia gravis.
- Coverage will be limited to 12 months for C3 Glomerulopathy and IC-MPGN

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

1. Local Coverage Determination (LCD): Drugs and Biologicals, Coverage of, for Label and Off-Label Uses (L33394). Centers for Medicare and Medicaid Services (CMS). Accessed 2024 September.
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4. Ultomiris (ravulizumab-cwvz) [package insert]. Boston, MA: Alexion Pharmaceuticals, Inc. June 2024.
5. Empaveli (pegcetacoplan) [package insert]. Waltham, MA: Apellis Pharmaceuticals, Inc.; December 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).
- September 12, 2023: Removed Step Therapy requirements from Medical Necessity Guideline. Added the Limitation Refer to the Medicare Part B Step Therapy Medical Necessity Guideline for additional requirements. For PNH, updated criteria to diagnosis only. For aHUS, updated criteria to diagnosis only. For NMOSD, updated criteria for diagnosis and a positive serologic test for anti-aquaporin-4 antibodies. For generalized myasthenia gravis, added Reauthorization Criteria, removed age requirements, added provider specialty requirements, and updated the wording for the requirement to be a positive serologic test for anti-acetylcholine. Removed the Limitations The health plan may authorize initial coverage of Soliris (eculizumab) for up to 12 weeks for the treatment of atypical hemolytic uremic syndrome (aHUS) when coverage criteria are met, The health plan may reauthorize coverage of Soliris (eculizumab) for the treatment of atypical hemolytic uremic syndrome (aHUS) for up to 12 months if reauthorization criteria are met, The health plan may authorize coverage of Soliris (eculizumab) for up to 12 months for the treatment of Paroxysmal Nocturnal Hemoglobinuria (PNH), generalized myasthenia gravis (gMG), or neuromyelitis Optica spectrum disorder (NMOSD) when coverage criteria are met, and Any indications other than FDA-approved indications are considered experimental or investigational and will not be approved by the health plan (effective 12/1/23).
- November 2023: Administrative Updates: Rebranded from Tufts Health Unify to Tufts Health One Care for 2024 and administrative update in support of calendar year 2024 Medicare Advantage and PDP Final Rule.
- August 13, 2024: Updated Medical Necessity Guideline title from Soliris to Complement Inhibitors and added existing coverage criteria for Empaveli and Ultomiris to the Medical Necessity Guideline. Based on L33394, added coverage criteria for Soliris for biopsy proven dense deposit disease. Added Ultomiris to the existing coverage criteria for NMOSD based on the supplemental indication for this condition (eff 10/1/24).
- September 2024: Joint Medical Policy and Health Care Services UM Committee review (eff 10/1/24).
- December 10, 2024: Added PiaSky to the Medical Necessity Guideline. Administrative update to remove HCPCS code C9151; included in error. (eff 1/1/25).
- December 2024: Joint Medical Policy and Health Care Services UM Committee review (eff 1/1/25).
- March 11, 2025: Administrative update to remove J Code, J1300 and adding J Code, J1299 (effective 4/1/25).
- March 2025 Joint Medical Policy and Health Care Services UM Committee review" (eff 4/1/25)
- December 2025: Administrative update: removed Harvard Pilgrim Health Care Stride Medicare Advantage from the Medical Necessity Guideline template; added C3 Glomerulopathy and IC-MPGN indication for Empaveli (eff 1/1/26)
- December 2025: Joint Medical Policy and Health Care Services UM Committee review (effective 1/1/26)

Background, Product and Disclaimer Information

Point32Health prior authorization criteria to be applied to Medicare Advantage plan members is based on guidance from Medicare laws, National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). When no guidance is provided, Point32Health uses clinical practice guidance published by relevant medical societies, relevant medical literature, Food and Drug Administration (FDA)-approved package labeling, and drug compendia to develop prior authorization criteria to apply to Medicare Advantage plan members. Medications that require prior authorization generally meet one or more of the following criteria: Drug product has the potential to be used for cosmetic purposes; drug product is not considered as first-line treatment by medically accepted practice guidelines, evidence to support the safety and efficacy of a drug product is poor, or drug product has the potential to be used for indications outside of the indications approved by the FDA. Prior authorization and use of the coverage criteria within this Medical Necessity Guideline will ensure drug therapy is medically necessary, clinically appropriate, and aligns with evidence-based guidelines. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests revisions.

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.