Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines
Medical Benefit Drugs

Enzyme Replacement Therapy: Loargys (pegzilarginase-nbln)

Effective: September 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

Public Plans Products

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

☐ Tufts Health Together – MassHealth 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 (FDA) - Approved Indications:

Loargys (Pegzilarginase-nbln) is an arginine-specific enzyme indicated for the treatment of hyperargininemia in adult and pediatric patients ≥ 2 years of age with ARG1-D, in conjunction with dietary protein restriction.

Clinical Guideline Coverage Criteria

The plan may authorize coverage of Loargys (Pegzilarginase-nbln) for Members when **ALL** of the following criteria are met:

Initial Authorization Criteria

1. Documented hyperargininemia or Arginase-1 deficiency (ARG1-D) diagnosis confirmed by any of the following enzymatic, biochemical, or genetic testing:
   a. Persistently elevated plasma arginine (pArg) levels (>230 µmol/L)
   b. Pathogenic variants in ARG1 gene
   c. Diminished erythrocyte ARG1 activity of a red blood cell (RBC) arginase assay showing < 1% activity

AND

2. The member is ≥2 years of age

AND

3. Documentation the medication will be used in conjunction with a protein-restricted diet

AND

4. Prescribed in consultation with a metabolic disease specialist or neurologist experienced in urea cycle disorders (UCDs)

Reauthorization Criteria

1. The member has a documented response to Loargys with pArg levels of 40 µmol/L–115 µmol/L

Limitations

1. Initial approvals with be authorized for 6 (six) months and reauthorizations will be provided in 12-month intervals.
2. Members new to the plan and stable on the medication will be reviewed against reauthorization criteria.

Codes

The following code(s) require prior authorization:

Table 1: HCPCS Codes

HCPCS Codes	Description
J1818	Injection, pegzilarginase-nbln, 0.05 mg

References

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- ClinicalTrials.gov. A Study of AEB1102 (Pegzilarginase) in patients with arginase I deficiency (AEB1102). ClinicalTrials.gov identifier: NCT03378531. Updated July 27, 2023. Accessed April 12, 2026. https://clinicaltrials.gov/study/NCT03378531?term=NCT03378531&viewType=Card&rank=1
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- National Organization for Rare Disorders (NORD). Arginase-1 deficiency. NORD. April 11, 2023. Accessed April 6, 2026. https://rarediseases.org/rare-diseases/arginase-deficiency/
- Russo RS, Gasperini S, Bubb G, et al. Efficacy and safety of pegzilarginase in arginase 1 deficiency (PEACE): a phase 3, randomized, double-blind, placebo-controlled, multi-centre trial. *EClinicalMedicine*. 2024;68:102405. Published 2024 Jan 12. doi:10.1016/j.eclinm.2023.102405
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Approval And Revision History

August e-vote 2026: Reviewed by Pharmacy and Therapeutics Committee (P&T)

Subsequent endorsement date(s) and changes made:

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.