Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:
Medical Benefit Drugs
Izervay™ (avacincaptad pegol)

Effective: June 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 - Approved Indications

Izervay (avacincaptad pegol) is a complement inhibitor indicated for the treatment of geographic atrophy (GA) secondary to age-related macular degeneration.

Clinical Guideline Coverage Criteria

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

Initial Authorization Criteria

1. Documented diagnosis of geographic atrophy secondary to age-related macular degeneration

AND

2. Patient is at least 18 years of age or older

AND

3. Prescribed by an ophthalmologist

Reauthorization Criteria

1. Documented diagnosis of geographic atrophy secondary to age-related macular degeneration

AND

2. Patient is at least 18 years of age or older

AND

3. Prescribed by an ophthalmologist

AND

4. Documentation the patient is responding positively to therapy (e.g., disease stabilization or slowing of the rate of disease progression compared to pre-treatment baseline)

Limitations

- Initial coverage of Izervay will be authorized for 6 months. Reauthorization of Izervay will be provided in 12 month intervals.
- Patients new to the plan stable on Izervay should be reviewed against Reauthorization Criteria.

Codes

The following code(s) require prior authorization:

Table 1: HCPCS Codes

HCPCS Codes	Description
J2782	Injection, avacincaptad pegol, 0.1 mg

References:

1. Flaxel CJ, et al. Age-related macular degeneration preferred practice pattern. Ophthalmology. 2020;127(1):P1-65.
2. Jaffe GJ, et al. C5 Inhibitor avacincaptad pegol for geographic atrophy due to age-related macular degeneration: a randomized pivotal phase 2/3 trial. Ophthalmology. 2021;128(4):576-586.
3. Izervay (avacincaptad pegol) [package insert]. Parsippany, NJ: IVERIC bio, Inc.; February 2026.
4. Patel SS, et al. Avacincaptad pegol for geographic atrophy secondary to age-related macular degeneration: 18-month findings from the GATHER1 trial. Eye. 2023;37:3551-3557

Approval And Revision History

December 12, 2023: Reviewed by the Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

- April 1, 2024: Administrative Updates: Removed C Code 9162 and added J Code J2782 to Medical Necessity Guideline.
- April 9, 2024: No changes. Effective May 6, 2024, removed Tufts Health Together from Medical Necessity Guideline. Coverage for Tufts Health Together falls under Unified Medical Policies Medical Necessity Guideline (effective 5/6/24).
- May 13, 2025: Updated age requirements to at least 18 years of age. Removed documentation of the absence of choroidal neovascularization in the treated eye(s). Administrative update to remove Harvard Pilgrim Health Care Stride Medicare Advantage from the Medical Necessity Guideline template (eff 6/1/25).
- May 12, 2026: Updated reauthorization duration to 12 month intervals, as label was updated without limitation on duration. Administrative updates: Template updated to remove CareLink from the Medical Necessity Guideline template. Template updated from “Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans” to “Tufts Health Together- MassHealth Accountable Care Partnership Plans.” (eff 6/1/26)

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.