Clinical Policy: Eculizumab (Soliris), Eculizumab-aeeb (Bkemv), Eculizumab-aagh (Epysqli)

Reference Number: CP.PHAR.97
Effective Date: 03.01.12
Last Review Date: 08.25
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Eculizumab (Soliris®) and its biosimilars, eculizumab-aeeb (Bkemv™) and eculizumab-aagh (Epysqli®), are complement inhibitors.

FDA Approved Indication(s)

Soliris, Bkemv, and Epysqli are indicated for the treatment of:

- Patients with paroxysmal nocturnal hemoglobinuria (PNH) to reduce hemolysis
- Patients with atypical hemolytic uremic syndrome (aHUS) to inhibit complement-mediated thrombotic microangiopathy (TMA)
- Adult patients with generalized myasthenia gravis (gMG) who are anti-acetylcholine receptor (AChR) antibody positive

Soliris is additionally indicated for the treatment of:

- Pediatric patients 6 years of age and older with gMG who are anti-AChR antibody positive
- Adult patients with neuromyelitis optica spectrum disorder (NMOSD) who are anti-aquaporin-4 (AQP4) antibody positive

Limitation(s) of use: Soliris, Bkemv, and Epysqli are not indicated for the treatment of patients with Shiga toxin *E. coli* related hemolytic uremic syndrome (STEC-HUS).

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Soliris, Bkemv, and Epysqli are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Paroxysmal Nocturnal Hemoglobinuria (must meet all)**:**

1. Diagnosis of PNH;
2. Prescribed by or in consultation with a hematologist;
3. Age ≥ 18 years;
4. Flow cytometry shows detectable glycosylphosphatidylinositol (GPI)-deficient hematopoietic clones or ≥ 10% PNH cells;
5. Member meets one of the following (a or b):
   a. History of ≥ 1 red blood cell transfusion in the past 24 months and (i or ii):

i. Documentation of hemoglobin < 7 g/dL in members without anemia symptoms;
ii. Documentation of hemoglobin < 9 g/dL in members with anemia symptoms;

b. History of thrombosis;

6. Soliris/Bkemv/Epysqli is not prescribed concurrently with Empaveli®, Fabhalta®, PiaSky®, or Ultomiris®, unless the member is in a 4-week period of cross-titration between Soliris/Bkemv/Epysqli and Empaveli*;
   **Provider must submit attestation of the presence or absence of concomitant Empaveli therapy*
7. Dose does not exceed 600 mg per week for the first 4 weeks, followed by 900 mg for the fifth dose 1 week later, then 900 mg every 2 weeks thereafter.

Approval duration: 6 months

B. Atypical Hemolytic Uremic Syndrome (must meet all)**:**
1. Diagnosis of aHUS (i.e., complement-mediated HUS);
2. Prescribed by or in consultation with a hematologist or nephrologist;
3. Age ≥ 2 months;
4. Member has signs of TMA as evidenced by all of the following (a, b, and c):
   a. Platelet count ≤ 150 x 10^9/L;
   b. Hemolysis such as an elevation in serum lactate dehydrogenase (LDH);
   c. Serum creatinine above the upper limits of normal or member requires dialysis;
5. Documentation that member does not have either of the following:
   a. A disintegrin and metalloproteinase with thrombospondin type 1 motif, member 13 (ADAMTS13) deficiency;
   b. STEC-HUS;
6. Soliris/Bkemv/Epysqli is not prescribed concurrently with Ultomiris;
7. Dose does not exceed one of the following (a or b):*
   a. Age ≥ 2 months and < 18 years: the FDA-approved maximum recommended dose (*see Section V*);
   b. Age ≥ 18 years: 900 mg per week for the first 4 weeks, followed by 1,200 mg for the fifth dose 1 week later, then 1,200 mg every 2 weeks thereafter.

   *Additional doses of eculizumab may be approved in the setting of concomitant plasmapheresis, plasma exchange, or fresh frozen plasma infusion (*see Appendix E*).

Approval duration: 6 months

C. Generalized Myasthenia Gravis (must meet all)**:**
1. Diagnosis of gMG;
2. Prescribed by or in in consultation with a neurologist;
3. Age ≥ 6 years;
4. Myasthenia Gravis-Activities of Daily Living (MG-ADL) score ≥ 6 at baseline;
5. Myasthenia Gravis Foundation of America (MGFA) clinical classification of Class II to IV;
6. Member has positive serologic test for anti-AChR antibodies;
7. Failure of a corticosteroid (*see Appendix B*), unless contraindicated or clinically significant adverse effects are experienced;*
   **For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*

8. Failure of a cholinesterase inhibitor (*see Appendix B*), unless contraindicated or clinically significant adverse effects are experienced;*
   **For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
9. Failure of at least one non-steroidal immunosuppressive therapy (*see Appendix B*), unless clinically significant adverse effects are experienced or all are contraindicated;*
   **For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
10. Soliris/Bkemv/Epysqli is not prescribed concurrently with Rystiggo®, Ultomiris, Vyvgart®, Vyvgart® Hytrulo, or Zilbrysq®;
11. Dose does not exceed one of the following (a or b):*
    a. Age ≥ 6 years and < 18 years: the FDA-approved maximum recommended dose (*see Section V*);
    b. Age ≥ 18 years: 900 mg per week for the first 4 weeks, followed by 1,200 mg for the fifth dose 1 week later, then 1,200 mg every 2 weeks thereafter.

    *Additional doses of eculizumab may be approved in the setting of concomitant plasmapheresis, plasma exchange, fresh frozen plasma infusion, or intravenous immunoglobulin (IVIg) (*see Appendix E*).

Approval duration: 6 months

D. Neuromyelitis Optica Spectrum Disorder (must meet all)**:**
1. Diagnosis of NMOSD;
2. Prescribed by or in in consultation with a neurologist;
3. Age ≥ 18 years;
4. Member has positive serologic test for anti-AQP4 antibodies;
5. Member meets one of the following (a or b):
   a. History of at least two relapses during the previous 12 months;
   b. History of three relapses during the previous 24 months, with at least one relapse occurring in the last 12 months;
6. Baseline expanded disability status scale (EDSS) score of ≤ 7;
7. Failure of rituximab (*Ruxience™ and Truxima® are preferred*)* at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;^
   **Prior authorization may be required for rituximab*
   ^For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395
8. Soliris/Bkemv/Epysqli is not prescribed concurrently with rituximab, Enspryng®, Uplizna®, or Ultomiris;
9. Dose does not exceed 900 mg per week for the first 4 weeks, followed by 1,200 mg for the fifth dose 1 week later, then 1,200 mg every 2 weeks thereafter.*
   *Additional doses of eculizumab may be approved in the setting of concomitant plasmapheresis, plasma exchange, or fresh frozen plasma infusion (*see Appendix E*).

Approval duration: 6 months

E. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Paroxysmal Nocturnal Hemoglobinuria and Atypical Hemolytic Uremic Syndrome (must meet all)**:**
1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy as evidenced by, including but not limited to, improvement in any of the following parameters (a or b):
   a. PNH:
      i. Improved measures of intravascular hemolysis (e.g., normalization of LDH);
      ii. Reduced need for red blood cell transfusions;
      iii. Increased or stabilization of hemoglobin levels;
      iv. Less fatigue;
      v. Improved health-related quality of life;
      vi. Fewer thrombotic events;
   b. aHUS:
      i. Improved measures of intravascular hemolysis (e.g., normalization of LDH);
      ii. Increased or stabilized platelet counts;
      iii. Improved or stabilized serum creatinine or estimated glomerular filtration rate (eGFR);
      iv. Reduced need for dialysis;
3. Soliris/Bkemv/Epysqli is not prescribed concurrently with (a or b):
   a. PNH: Empaveli, Fabhalta, PiaSky, or Ultomiris;
   b. aHUS: Ultomiris;

4. If request is for a dose increase, new dose does not exceed (a or b):
   a. For PNH: 900 mg every 2 weeks;
   b. For aHUS*: 1,200 mg every 2 weeks.
   *Additional doses of eculizumab may be approved in the setting of concomitant plasmapheresis, plasma exchange, or fresh frozen plasma infusion (*see Appendix E*).

Approval duration: 12 months

B. Generalized Myasthenia Gravis (must meet all)**:**
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Soliris/Bkemv/Epysqli for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy as evidenced by a 2-point reduction from baseline in MG-ADL total score;
3. Soliris/Bkemv/Epysqli is not prescribed concurrently with Rystiggo, Ultomiris, Vyvgart, Vyvgart Hytrulo, or Zilbrysq;
4. If request is for a dose increase, new dose does not exceed 1,200 mg every 2 weeks.*
   *Additional doses of eculizumab may be approved in the setting of concomitant plasmapheresis, plasma exchange, fresh frozen plasma infusion, or IVIg (*see Appendix E*).

Approval duration: 12 months

C. Neuromyelitis Optica Spectrum Disorder (must meet all)**:**
1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy – including but not limited to improvement or stabilization in any of the following parameters:
   a. Frequency of relapse;
   b. EDSS;
   c. Visual acuity;
3. Soliris/Bkemv/Epysqli is not prescribed concurrently with rituximab, Enspryng, Uplizna, or Ultomiris;
4. If request is for a dose increase, new dose does not exceed 1,200 mg every 2 weeks.*
   *Additional doses of eculizumab may be approved in the setting of concomitant plasmapheresis, plasma exchange, or fresh frozen plasma infusion (*see Appendix E*).

Approval duration: 12 months

D. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or

b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents;

B. STEC-HUS;

C. Antiphospholipid syndrome (D68.61);

D. Unspecified nephritic syndrome with other morphologic changes (N05.8).

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AchR: acetylcholine receptor
ADAMTS13: a disintegrin and metalloproteinase with thrombospondin type 1 motif, member 13
aHUS: atypical hemolytic uremic syndrome
AQP-4: aquaporin-4
EDSS: Expanded Disability Status Scale
FDA: Food and Drug Administration
gMG: generalized myasthenia gravis
GPI: glycosylphosphatidylinositol
IVIg: intravenous immunoglobulin
LDH: lactate dehydrogenase
MG-ADL: Myasthenia Gravis-Activities of Daily Living
MGFA: Myasthenia Gravis Foundation of America
PNH: paroxysmal nocturnal hemoglobinuria
STEC-HUS: Shiga toxin E. coli related hemolytic uremic syndrome
TMA: thrombotic microangiopathy

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Corticosteroids		
betamethasone	Oral: 0.6 to 7.2 mg PO per day	7.2 mg/day
dexamethasone	Oral: 0.75 to 9 mg/day PO	9 mg/day
methylprednisolone	Oral: 12 to 20 mg PO per day; increase as needed by 4 mg every 2-3 days until there is marked clinical improvement or to a maximum of 40 mg/day	40 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
prednisone	Oral: 15 mg/day to 20 mg/day; increase by 5 mg every 2-3 days as needed. Maximum: 60 mg/day	60 mg/day
Cholinesterase Inhibitors		
pyridostigmine (Mestinon®, Regonol®)	Oral immediate-release: 600 mg daily in divided doses (range, 60-1500 mg daily in divided doses) Oral sustained release: 180-540 mg QD or BID IV or IM: 2 mg every 2-3 hours	See regimen
neostigmine (Bloxiverz®)	Oral: 15 mg TID. The daily dosage should be gradually increased at intervals of 1 or more days. The usual maintenance dosage is 15-375 mg/day (average 150 mg) IM or SC: 0.5 mg based on response to therapy	See regimen
Immunosuppressants		
azathioprine (Imuran®)	Oral: 50 mg QD for 1 week, then increase gradually to 2 to 3 mg/kg/day	3 mg/kg/day
mycophenolate mofetil (Cellcept®)*	Oral: Dosage not established. 1 gram BID has been used with adjunctive corticosteroids or other non-steroidal immunosuppressive medications	2 g/day
cyclosporine (Sandimmune®)*	Oral: initial dose of cyclosporine (Non-modified), 5 mg/kg/day in 2 divided doses	5 mg/kg/day
Rituxan® (rituximab), Riabni™ (rituximab-arrx), Ruxience™ (rituximab-pvvr), Truxima® (rituximab-abbs)*†	**gMG** IV: 375 mg/m^2 once a week for 4 weeks; an additional 375 mg/m^2 dose may be given every 1 to 3 months afterwards **NMOSD** IV: 375 mg/m^2 per week for 4 weeks as induction, followed by 375 mg/m^2 biweekly every 6 to 12 months	See regimen

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.
**Off-label*
†*Prior authorization is required for rituximab products*

Appendix C: Contraindications/Boxed Warnings
- Contraindication(s): unresolved serious *Neisseria meningitidis* infection
- Boxed warning(s): serious meningococcal infections

Appendix D: General Information
- Soliris/Bkemv/Epysqli is only available through a REMS (Risk Evaluation and Mitigation Strategy) program due to the risk of life-threatening and fatal meningococcal

infection. Patients should be vaccinated with a meningococcal vaccine at least 2 weeks prior to receiving the first dose of Soliris/Bkemv/Epysqli and revaccinated according to current medical guidelines for vaccine use. Patients should be monitored for early signs of meningococcal infections, evaluated immediately if infection is suspected, and treated with antibiotics if necessary.

- The Advisory Committee on Immunization Practices (ACIP)'s recommendations regarding the meningococcal vaccine are found here: http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mening.html.
- Examples of positive response to therapy include:
  - PNH: improved measures of intravascular hemolysis (e.g., normalization of lactate dehydrogenase [LDH]), reduced need for red blood cell transfusions, less fatigue, improved health-related quality of life, fewer thrombotic events;
  - aHUS: decreased need for plasma therapy (plasma exchange or plasma infusion), decreased need for dialysis, increased glomerular filtration rate, normalization of platelet counts and/or LDH levels;
  - gMG: a 2-point reduction in MG-ADL total score is considered a clinically meaningful improvement. The scale can be accessed here: https://myasthenia.org/Portals/0/ADL.pdf;
  - NMOSD: stabilization or reduction in EDSS total score. EDSS ranges from 0 (no disability) to 10 (death).
- The MGFA classification has some subjectivity in it when it comes to distinguishing mild (Class II) from moderate (Class III) and moderate (Class III) from severe (Class IV). Furthermore, it is insensitive to change from one visit to the next.
- AQP-4: AQP-4-IgG-seroposotive status is confirmed with the use of commercially available cell-binding kit assay (Euroimmun).
- Ultomiris is a humanized monoclonal antibody to complement component C5 that was engineered from Soliris. It is virtually identical to Soliris but has a longer half-life that allows for less frequent dosing intervals.
- Coverage is excluded for the following indications. The use of Soliris/Bkemv/Epysqli for these indications is considered investigational due to lack of conclusive, evidence-based data with randomized controlled trials. As such, alternative therapies for these indications include:
  - Antiphospholipid syndrome: anticoagulation therapy (e.g., vitamin K antagonists)
  - Unspecified nephritic syndrome with other morphologic changes: immunosuppression (e.g., prednisone, mycophenolate mofetil)
- In October 2021, the Institute for Clinical and Economic Review (ICER) published a final evidence report on the effectiveness and value of Soliris for the treatment of gMG. In adults with gMG positive for anti-AChR antibodies refractory to conventional therapy, there is:
  - Moderate certainty of a small or substantial net health benefit with high certainty of at least a small benefit for Soliris added to conventional therapy compared with conventional therapy alone (B+);
  - Insufficient evidence (I) to distinguish the net health benefits of rituximab from Soliris.

- The 2020 MGFA international consensus guidelines for gMG recommend that Soliris be considered after trials of other immunotherapies have been unsuccessful in meeting treatment goals. Soliris is a treatment option for severe, refractory, AChR antibody positive gMG.

Appendix E: Dose Adjustment in Case of Plasmapheresis, Plasma Exchange, Fresh Frozen Plasma Infusion, or IVIg

- For aHUS, gMG, and NMOSD, supplemental dosing of eculizumab is required in the setting of concomitant plasmapheresis, plasma exchange, or fresh frozen plasma infusion.
- Additionally for gMG, a supplemental dose of eculizumab is required in the setting of concomitant use of IVIg treatment.

Type of plasma intervention	Most recent eculizumab dose	Supplemental eculizumab dose with each intervention
Plasmapheresis or plasma exchange	300 mg	300 mg per each plasmapheresis or plasma exchange session
	≥ 600 mg	600 mg per each plasmapheresis or plasma exchange session
Fresh frozen plasma infusion	≥ 300 mg	300 mg per infusion of fresh frozen plasma
IVIg acute rescue therapy	No supplemental eculizumab dose needed	
IVIg frequency equal to or more frequent than every 4 weeks	≥ 900 mg	600 mg at the same time as scheduled eculizumab dose
	≤ 600 mg	300 mg at the same time as scheduled eculizumab dose
IVIg less frequent than every 4 weeks	≥ 900 mg	600 mg at the next scheduled eculizumab dose after the last IVIg cycle
	≤ 600 mg	300 mg at the next scheduled eculizumab dose after the last IVIg cycle

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Soliris, Bkemv, Epysqli	PNH	IV infusion: 600 mg weekly for the first 4 weeks, followed by 900 mg for the fifth dose 1 week later, then 900 mg every 2 weeks thereafter	900 mg/dose
	aHUS	Adults: IV infusion: 900 mg weekly for the first 4 weeks, followed by 1,200 mg for the fifth dose 1 week later, then 1,200 mg every 2 weeks thereafter* Pediatric: IV infusion based on body weight:*	Adult: 1,200 mg/dose Pediatric: Varies by weight

<table>
<tr><th>Drug Name</th><th>Indication</th><th>Dosing Regimen</th><th>Maximum Dose</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th>Body weight</th><th>Induction</th><th>Maintenance</th></tr>
<tr><td>≥ 40 kg</td><td>900 mg weekly for 4 doses</td><td>1,200 mg at week 5; then 1,200 mg every 2 weeks</td></tr>
<tr><td>30 kg to < 40 kg</td><td>600 mg weekly for 2 doses</td><td>900 mg at week 3; then 900 mg every 2 weeks</td></tr>
<tr><td>20 kg to < 30 kg</td><td>600 mg weekly for 2 doses</td><td>600 mg at week 3; then 600 mg every 2 weeks</td></tr>
<tr><td>10 kg to < 20 kg</td><td>600 mg single dose</td><td>300 mg at week 2; then 300 mg every 2 weeks</td></tr>
<tr><td>5 kg to < 10 kg</td><td>300 mg single dose</td><td>300 mg at week 2; then 300 mg every 3 weeks</td></tr>
</table>
*Additional doses of eculizumab are appropriate in the setting of concomitant plasmapheresis, plasma exchange, or fresh frozen plasma infusion *(see Appendix E).*</td><td></td></tr>
<tr><td>Soliris, Bkemv, Epysqli</td><td>gMG</td><td>Adult:
IV infusion: 900 mg weekly for the first 4 weeks, followed by 1,200 mg for the fifth dose 1 week later, then 1,200 mg every 2 weeks thereafter*

Pediatric: IV infusion based on body weight:*
<table>
<tr><th>Body weight</th><th>Induction</th><th>Maintenance</th></tr>
<tr><td>≥ 40 kg</td><td>900 mg weekly for 4 doses</td><td>1,200 mg at week 5; then 1,200 mg every 2 weeks</td></tr>
<tr><td>30 kg to < 40 kg</td><td>600 mg weekly for 2 doses</td><td>900 mg at week 3; then 900 mg every 2 weeks</td></tr>
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</table>
*Additional doses of eculizumab are appropriate in the setting of concomitant plasmapheresis, plasma exchange, fresh frozen plasma infusion, or IVIg treatment *(see Appendix E).*</td><td>Adult: 1,200 mg/dose

Pediatric: Varies by weight</td></tr>
</table>

Drug Name	Indication	Dosing Regimen	Maximum Dose
Soliris	NMOSD	IV infusion: 900 mg weekly for the first 4 weeks, followed by 1,200 mg for the fifth dose 1 week later, then 1,200 mg every 2 weeks thereafter* *Additional doses of eculizumab are appropriate in the setting of concomitant plasmapheresis, plasma exchange, or fresh frozen plasma infusion *(see Appendix E)*.	1,200 mg/dose

VI. Product Availability

Drug Name	Availability
Soliris	Single-dose vial: 300 mg/30 mL
Bkemv	Single-dose vial: 300 mg/30 mL
Epysqli	Single-dose vial: 300 mg/30 mL

VII. References

1. Soliris Prescribing Information. Boston, MA: Alexion Pharmaceuticals, Inc.; February 2025. Available at: https://alexion.us/-/media/alexion_global/documents/regulatory/north-america/usa/2024/english/soliris_uspi.pdf. Accessed April 30, 2025.
2. Bkemv Prescribing Information. Thousand Oaks, CA: Amgen Inc.; October 2024. Available at: https://www.pi.amgen.com/-/media/Project/Amgen/Repository/pi-amgen-com/BKEMV/BKEMV_fpi_hcp_english.pdf. Accessed April 30, 2025.
3. Epysqli Prescribing Information. Yeonsu-gu, Incheon: Samsung Bioepis Co., Ltd.; April 2025. Available at: https://www.epysqli.com/globalassets/epysqli/prescribing-information.pdf. Accessed April 30, 2025.

PNH

4. Parker C, Omine M, Richards S, et al. Diagnosis and management of paroxysmal nocturnal hemoglobinuria. Blood 2005; 106(12):3699-3709. doi:10.1182/blood-2005-04-1717.
5. Borowitz MJ, Craig FE, DiGiuseppe JA, et al. Guidelines for the diagnosis and monitoring of paroxysmal nocturnal hemoglobinuria and related disorders by flow cytometry. Cytometry Part B (Clinical Cytometry). 2010; 78B: 211–230.

aHUS

6. Loirat C, Fakhouri F, Ariceta G, et al. An international consensus approach to the management of atypical hemolytic uremic syndrome in children. Pediatr Nephrol. 2016; 31: 15-39.
7. Avila A, Cao M, Espinosa M, Manrique J, Morales E. Recommendations for the individualized management of atypical hemolytic uremic syndrome in adults. Front Med. 2023; 10: 1264310. doi: 1.3389.fmed.2023.1264310
8. Goodship THJ, Cook HT, Fakhouri F, et al. Atypical hemolytic uremic syndrome and C3 glomerulopathy: conclusions from a “Kidney Disease: Improving Global Outcomes” (KDIGO) Controversies Conference. Kidney International. 2017; 91: 539-551.
9. Vivarelli M, Barratt J, Beck LH, et al. The role of complement in kidney disease: Conclusions from a Kidney Disease: Improving Global Outcomes (KDIGO) Controversies Conference. Kidney International. 2024; 106: 369-391.

gMG

10. Howard JF, et al. Safety and efficacy of eculizumab in anti-acetylcholine receptor antibody-positive refractory generalised myasthenia gravis (REGAIN): a phase 3, randomised, double-blind, placebo-controlled, multicenter study. Lancet Neurol. 2017; 16(12): 976-986.
11. Sanders DB, Wolfe GI, Benatar M, et al. International consensus guidelines for the management of myasthenia gravis. Neurology. 2016; 87: 419-425.
12. Narayanaswami P, Sanders DB, Wolfe G, et al. International consensus guidance for management of myasthenia gravis: 2020 update. Neurology. 2021; 96: 114-122.
13. Muppidi S. The myasthenia gravis-specific activities of daily living profile. Ann N Y Acad Sci. 2012; 1274:114-119.
14. Institute for Clinical and Economic Review. Eculizumab and efgartigimod for the treatment of myasthenia gravis: effectiveness and value: Effectiveness and value (final report). Published October 20, 2021. Available at: https://icer.org/assessment/myasthenia-gravis. Accessed April 30, 2025.

NMOSD

15. Pittock SJ, et al. Eculizumab in aquaporin-4-postive neuromyelitis optica spectrum disorder. NEJM. May 2019. DOI:10.1056.
16. Sellner J, Boggild M, Clanet M, et al. EFNS guidelines on diagnosis and management of neuromyelitis optica. European Journal of Neurology. 2010; 17: 1019–1032.
17. Kumpfel T, Giglhuber K, Aktas O, et al. Update on the diagnosis and treatment of neuromyelitis optica spectrum disorders (NMOSD) – revised recommendations of the Neuromyelitis Optica Study Group (NEMOS). Part II: Attack therapy and long-term management. Journal of Neurology. 2023; 271: 141-176.

Other

18. Canaud G, Kamar N, Anglicheau D, et al. Eculizumab improves posttransplant thrombotic microangiopathy due to antiphospholipid syndrome recurrence but fails to prevent chronic vascular changes. Am J Transplant. 2013;13(8):2179-2185.
19. Lebreton C, Bacchetta J, Dijoud F, et al. C3 glomerulopathy and eculizumab: A report on four paediatric cases. Pediatr Nephrol. 2017;32(6):1023-1028.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J1299	Injection, eculizumab, 2 mg
Q5151	Injection, eculizumab-aagh (epysqli), biosimilar, 2 mg
Q5152	Injection, eculizumab-aeeb (bkemv), biosimilar, 2 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2021 annual review: for PNH and aHUS, added requirement against concurrent use with Ultomiris; for NMOSD, specified that Ruxience is the preferred rituximab product; references to	10.20.20	02.21

Reviews, Revisions, and Approvals	Date	P&T Approval Date
HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.		
1Q 2022 annual review: no significant changes; for PNH, added restriction against concomitant use of Empaveli with Soliris with an exception for the initial 4-week cross-titration phase to align with previously approved approach for Empaveli; for NMOSD, specified that Truxima is also a preferred rituximab product; references reviewed and updated.	09.15.21	02.22
Per February SDC and prior clinical guidance, for NMOSD added stepwise redirection requirement if member has failed rituximab, then member must use Enspryng.	02.17.22	05.22
Per August SDC and prior clinical guidance, for NMOSD, removed redirection to Enspryng; for gMG modified from two to one immunosuppressive therapy required, added requirement that Soliris is not prescribed concurrently with Ultomiris or Vyvgart. Template changes applied to other diagnoses/indications and continued therapy section.	08.23.22	11.22
1Q 2023 annual review: no significant changes; references reviewed and updated.	11.03.22	02.23
3Q 2023 annual review: no significant changes; references reviewed and updated.	04.19.23	08.23
3Q 2024 annual review: RT4: added newly approved biosimilar, Bkemv; updated the list of therapies that Soliris/Bkemv should not be prescribed concurrently with to include Rystiggo, Vyvgart Hytrulo, and Zilbrysq for gMG, Fabhalta for PNH, and Ultomiris for NMOSD; revised contraindications in Appendix C per updated Soliris prescribing information; references reviewed and updated. RT4: added newly approved biosimilar, Epysqli.	07.25.24	08.24
HCPCS code added [Q5139] and removed codes [J3590, C9399] RT4: updated FDA approved indication for Epysqli to include adult patients with gMG who are AChR antibody positive; for gMG continuation of therapy requests, extended continuity of care allowance to Bkemv and Epysqli; for NMOSD, clarified relapse requirements per PA ops request.	11.26.24	
HCPCS codes added [J1299, Q5151, Q5152], removed codes [J1300, Q5139]. RT4: updated FDA approved indication for Soliris to include gMG 6 years old pediatric expansion; for aHUS, gMG, and NMOSD per PI, updated dose maximum and added asterisk stating additional doses of eculizumab may be approved if the member is receiving plasmapheresis, plasma exchange, fresh frozen plasma, or IVIg; added Appendix E to provide supplemental dosing information.	03.12.25	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2025 annual review: RT4: updated FDA approved indication for Bkemv to include adult patients with gMG who are AChR antibody positive; for PNH, added PiaSky to the list of therapies that Soliris/Bkemv/Epysqli should not be prescribed concurrently with; for gMG, clarified that the required immunosuppressive therapy should be non-steroidal; revised continued approval duration from 6 to 12 months for all indications as they are chronic conditions; references reviewed and updated. Added step therapy bypass for IL HIM per IL HB 5395.	06.24.25	08.25

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to

recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.