Complement Inhibitors (for Ohio Only)

Policy Number: CSOH2026D0049.H
Effective Date: April 1, 2026

➲ Instructions for Use

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Related Policies

None

Application

This Medical Benefit Drug Policy only applies to the state of Ohio. Any requests for services that are stated as unproven or services for which there is a coverage or quantity limit will be evaluated for medical necessity using Ohio Administrative Code 5160-1-01.

Coverage Rationale

This policy refers only to the following complement inhibitor drug products:

- Bkemv™ (eculizumab-aeeb)
- Epysqli® (eculizumab-aagh)
- PiaSky® (crovalimab-akkz)
- Soliris® (eculizumab)
- Ultomiris® (ravulizumab-cwvz)

Zilbrysq (zilucoplan) is a self-administered injection obtained under the member's pharmacy benefit.

The following complement inhibitors are proven and medically necessary for the treatment of certain conditions outlined within the InterQual® criteria. For medical necessity clinical coverage criteria, refer to the current release of the InterQual® guideline:

- Bkemv (eculizumab-aeeb): CP: Specialty Rx Non-Oncology, Eculizumab-aeeb (Bkemv)
- Epysqli (eculizumab-aagh): CP: Specialty Rx Non-Oncology, Eculizumab-aagh (Epysqli)
- Soliris (eculizumab): CP: Specialty Rx Non-Oncology, Eculizumab (Soliris)

Click here to view the InterQual® criteria.

Ultomiris is proven and medically necessary for the treatment of atypical hemolytic uremic syndrome (aHUS) when all of the following criteria are met:

- **Initial Therapy**
  - Documentation supporting the diagnosis of aHUS by ruling out **both** of the following:
    - Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS); **and**
    - Thrombotic thrombocytopenia purpura (TTP) (e.g., rule out ADAMTS13 deficiency)

    and
  - Laboratory results, signs, and/or symptoms attributed to aHUS (e.g., thrombocytopenia, microangiopathic hemolysis, thrombotic microangiopathy, acute renal failure, etc.); **and**

- Patient is treatment naïve with Ultomiris; **and**
- Ultomiris is dosed according to the U.S. FDA labeled dosing for aHUS; **and**
- Prescribed by, or in consultation with, a hematologist or nephrologist; **and**
- Initial authorization will be for no more than 12 months

- **Continuation of Therapy**
  - Patient has previously been treated with Ultomiris; **and**
  - Documentation demonstrating a positive clinical response from baseline (e.g., reduction of plasma exchanges, reduction of dialysis, increased platelet count, reduction of hemolysis); **and**
  - Ultomiris is dosed according to the U.S. FDA labeled dosing for aHUS; **and**
  - Prescribed by, or in consultation with, a hematologist or nephrologist; **and**
  - Reauthorization will be for no more than 12 months

PiaSky and Ultomiris are unproven and not medically necessary for the treatment of Shiga toxin E. coli-related hemolytic uremic syndrome (STEC-HUS).

PiaSky and Ultomiris are proven and medically necessary for the treatment of paroxysmal nocturnal hemoglobinuria (PNH) when all of the following criteria are met:

- **Initial Therapy**
  - Documentation supporting the diagnosis of PNH that includes **both** of the following:
    - Flow cytometry analysis confirming presence of PNH clones; **and**
    - Laboratory results, signs, and/or symptoms attributed to PNH (e.g., abdominal pain, anemia, dyspnea, extreme fatigue, smooth muscle dystonia, unexplained/unusual thrombosis, hemolysis/hemoglobinuria, kidney disease, pulmonary hypertension, etc.)

    and
  - For PiaSky authorization only, **both** of the following:
    - History of trial and failure, contraindication, or intolerance to **one** of the following:
      - Empaveli (pegcetacoplan)
      - Fabhalta (iptacopan)
      - Eculizumab or Ultomiris (ravulizumab)
    - Patient is **not** receiving PiaSky in combination with a complement factor D inhibitor [e.g., Voydeya (danicopan)]

    and
  - PiaSky or Ultomiris are dosed according to the U.S. FDA labeled dosing for PNH; **and**
  - Patient is **not** receiving PiaSky or Ultomiris in combination with another complement protein C5 inhibitor, a complement protein C3 inhibitor [e.g., Empaveli (pegcetacoplan)], or a complement factor B inhibitor [e.g., Fabhalta (iptacopan)]; **and**
  - Prescribed by, or in consultation with, a hematologist or oncologist; **and**
  - Initial authorization will be for no more than 12 months
- **Continuation of Therapy**
  - Patient has previously been treated with PiaSky or Ultomiris; **and**
  - Documentation demonstrating a positive clinical response from baseline (e.g., increased or stabilization of hemoglobin levels, reduction in transfusions, improvement in hemolysis, decrease in LDH, increased reticulocyte count, etc.); **and**
  - PiaSky or Ultomiris are dosed according to the U.S. FDA labeled dosing for PNH; **and**
  - Patient is **not** receiving PiaSky or Ultomiris in combination with another complement protein C5 inhibitor, a complement protein C3 inhibitor [e.g., Empaveli (pegcetacoplan)], or a complement factor B inhibitor [e.g., Fabhalta (iptacopan)]; **and**
  - For PiaSky authorization only:
    - Patient is **not** receiving PiaSky in combination with a complement factor D inhibitor [e.g., Voydeya (danicopan)]

    and
  - Prescribed by, or in consultation with, a hematologist or oncologist; **and**
  - Reauthorization will be for no more than 12 months

Ultomiris is proven and medically necessary for the treatment of generalized myasthenia gravis in patients who are anti-AChR antibody positive when all of the following criteria are met:

- **Initial Therapy**
  - Submission of medical records (e.g., chart notes, laboratory values, etc.) confirming **all** of the following:
    - Patient has not failed a previous course of Ultomiris therapy; **and**
    - Diagnosis of generalized myasthenia gravis (gMG); **and**

        - Positive serologic test for anti-AChR antibodies; **and**
        - Patient has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of class II, III, or IV at initiation of therapy; **and**
        - Patient has a Myasthenia Gravis Activities of Daily Living (MG-ADL) scale total score ≥ 6 at initiation of therapy

      and
    - **One** of the following:
        - History of failure of at least **two** immunosuppressive agents over the course of at least 12 months (e.g., azathioprine, corticosteroids, cyclosporine, methotrexate, mycophenolate, etc.); **or**
        - Patient has a history of failure of at least **one** immunosuppressive therapy and has required four or more courses of plasmapheresis/plasma exchanges and/or intravenous immune globulin over the course of at least 12 months without symptom control

      and
    - Ultomiris is initiated and titrated according to the U.S. FDA labeled dosing for gMG; **and**
    - Patient is **not** receiving Ultomiris in combination with any of the following for treatment of the same indication:
        - B-cell depletion therapy [e.g., Uplizna (inebilizumab)]; **and**
        - A different complement C5 inhibitor [i.e., Bkemv (eculizumab-aeeb), Epysqli (eculizumab-aagh), PiaSky (crovalimab), Soliris (eculizumab), Ultomiris (ravulizumab), or Zilbrysq (Zilucoplan)]; **and**
        - An FcRN blocker [e.g., Vyvgart (efgartigimod alfa-fcab), Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc), Rystiggo (rozanolixizumab-noli)]; **and**
        - An immune globulin (e.g., Hizentra, Privigen, Gammagard)

      and
    - Prescribed by, or in consultation with, a neurologist; **and**
    - Initial authorization will be for no more than 12 months
- **Continuation of Therapy**
    - Patient has previously been treated with Ultomiris; **and**
    - Submission of medical records (e.g., chart notes, laboratory tests) demonstrating **all** of the following:
        - Improvement and/or maintenance of at least a 2-point improvement (reduction in score) in the MG-ADL score from pre-treatment baseline; **and**
        - Reduction in signs and symptoms of myasthenia gravis; **and**
        - Maintenance, reduction, or discontinuation of dose(s) of baseline immunosuppressive therapy (IST) prior to starting eculizumabor Ultomiris
          Note: Add on, dose escalation of IST, or additional rescue therapy from baseline to treat myasthenia gravis or exacerbation of symptoms while on eculizumab or Ultomiris therapy will be considered as treatment failure.

      and
    - Ultomiris is dosed according to the U.S. FDA labeled dosing for gMG; **and**
    - Patient is **not** receiving Ultomiris in combination with any of the following for treatment of the same indication:
        - B-cell depletion therapy [e.g., Uplizna (inebilizumab)]; **and**
        - A different complement C5 inhibitor [i.e., Bkemv (eculizumab-aeeb), Epysqli (eculizumab-aagh), PiaSky (crovalimab), Soliris (eculizumab), Ultomiris (ravulizumab), or Zilbrysq (Zilucoplan)]; **and**
        - An FcRN blocker [e.g., Vyvgart (efgartigimod alfa-fcab), Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc), Rystiggo (rozanolixizumab-noli)]; **and**
        - An immune globulin (e.g., Hizentra, Privigen, Gammagard)

      and
    - Prescribed by, or in consultation with, a neurologist; **and**
    - Reauthorization will be for no more than 12 months

Ultomiris is proven and medically necessary for the treatment of neuromyelitis optica spectrum disorder (NMOSD) when all of the following criteria are met:

- **Initial Therapy**
    - Diagnosis of neuromyelitis optica spectrum disorder (NMOSD) by a neurologist confirming **all** of the following:
        - Past medical history of **one** of the following:
            - Optic neuritis; **or**
            - Acute myelitis; **or**
            - Area postrema syndrome: episode of otherwise unexplained hiccups or nausea and vomiting; **or**
            - Acute brainstem syndrome; **or**
            - Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions; **or**
            - Symptomatic cerebral syndrome with NMOSD-typical brain lesions

          and

        - Positive serologic test for anti-aquaporin-4 immunoglobulin G (AQP4-IgG)/NMO-IgG antibodies; **and**
        - Diagnosis of multiple sclerosis or other diagnoses have been ruled out

      and
    - Patient has not failed a previous course of Ultomiris therapy; **and**
    - History of failure of, contraindication, or intolerance to rituximab therapy; **and**
    - Ultomiris is initiated and titrated according to the U.S. FDA labeled dosing for NMOSD; **and**
    - Prescribed by, or in consultation with, a neurologist; **and**
    - Patient is **not** receiving Ultomiris in combination with **any** of the following:
        - Disease modifying therapies for the treatment of multiple sclerosis [e.g., Gilenya (fingolimod), Tecfidera (dimethyl fumarate), Ocrevus (ocrelizumab), etc.]
        - Anti-IL6 therapy [e.g., Actemra (tocilizumab), Enspryng (satralizumab)]
        - B-cell depletion therapy [e.g., rituximab, Uplizna (inebilizumab-cdon)]

      and
    - Initial authorization will be for no more than 12 months
- **Continuation of Therapy**
    - Patient has previously been treated with Ultomiris; **and**
    - Documentation of positive clinical response from baseline as demonstrated by at least **both** of the following:
        - Reduction in the number and/or severity of relapses or signs and symptoms of NMOSD; **and**
        - Maintenance, reduction, or discontinuation of dose(s) of any baseline immunosuppressive therapy (IST) prior to starting Ultomiris

          Note: Add on, dose escalation of IST, or additional rescue therapy from baseline to treat NMOSD or exacerbation of symptoms while on Ultomiris therapy will be considered as treatment failure.

      and
    - Ultomiris is dosed according to the U.S. FDA labeled dosing for NMOSD; **and**
    - Prescribed by, or in consultation with, a neurologist; **and**
    - Patient is **not** receiving Ultomiris in combination with **any** of the following:
        - Disease modifying therapies for the treatment of multiple sclerosis [e.g., Gilenya (fingolimod), Tecfidera (dimethyl fumarate), Ocrevus (ocrelizumab), etc.]
        - Anti-IL6 therapy [e.g., Actemra (tocilizumab), Enspryng (satralizumab)]
        - B-cell depletion therapy [e.g., rituximab, Uplizna (inebilizumab-cdon)]

      and
    - Reauthorization will be for no more than 12 months

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
J1303	Injection, ravulizumab-cwvz, 10 mg
J1307	Injection, crovalimab-akkz, 10 mg
Q5151	Injection, eculizumab-aagh (epysqli), biosimilar, 2 mg
Q5152	Injection, eculizumab-aeeb (bkemv), biosimilar, 2 mg

Diagnosis Code	Description
D59.30	Hemolytic-uremic syndrome, unspecified
D59.32	Hereditary hemolytic-uremic syndrome
D59.39	Other hemolytic-uremic syndrome
D59.5	Paroxysmal nocturnal hemoglobinuria [Marchiafava-Micheli]
G36.0	Neuromyelitis optica [Devic]
G70.00	Myasthenia gravis without (acute) exacerbation
G70.01	Myasthenia gravis with (acute) exacerbation

Background

Ravulizumab is a monoclonal antibody that bind with high affinity to complement protein C5, which inhibits its cleavage to C5a and C5b and prevents the generation of the terminal complement complex C5b9. In those patients with paroxysmal nocturnal hemoglobinuria (PNH), ravulizumab inhibits terminal complement mediated intravascular hemolysis.[1,12] In patients with atypical hemolytic uremic syndrome (aHUS), impairment in the regulation of complement activity leads to uncontrolled terminal complement activation, resulting in platelet activation, endothelial cell damage and thrombotic microangiopathy. The precise mechanism by which ravulizumab exerts its therapeutic effect in gMG patients is unknown but is presumed to involve reduction of terminal complement complex C5b-9 deposition at the neuromuscular junction.

Crovalimab-akkz is a monoclonal antibody that specifically binds with high affinity to the complement protein C5, inhibiting its cleavage into C5a and C5b, preventing the formation of the membrane attack complex (MAC). Crovalimab-akkz inhibits terminal complement-mediated intravascular hemolysis in patients with PNH.

Clinical Evidence

Proven

Atypical Hemolytic Uremic Syndrome (aHUS)

Ravulizumab is indicated for the treatment of atypical hemolytic uremic syndrome (aHUS).

Rondeau et al. evaluated the efficacy and safety of ravulizumab for the treatment of atypical hemolytic uremic syndrome in adults. In this global, phase 3, single arm study in complement inhibitor-naïve adults (18 years and older) who fulfilled diagnostic criteria for atypical hemolytic uremic syndrome, enrolled patients received ravulizumab through a 26-week initial evaluation period. Patients were required to have a platelet count ≤ 150 x 109 /L, evidence of hemolysis such as an elevation in serum LDH, and serum creatinine above the upper limits of normal or required dialysis. A total of 56 patients with aHUS were evaluated for efficacy. The primary endpoint was complete thrombotic microangiopathy response defined as normalization of platelet count and lactate dehydrogenase and 25% or more improvement in serum creatinine. The efficacy evaluation was based on Complete TMA Response during the 26-week Initial Evaluation Period, as evidenced by normalization of hematological parameters (platelet count and LDH) and ≥ 25% improvement in serum creatinine from baseline. Patients had to meet each Complete TMA Response criteria at 2 separate assessments obtained at least 4 weeks (28 days) apart, and any measurement in between. Secondary endpoints included changes in hematologic variables and renal function. Safety was also evaluated. Ravulizumab treatment resulted in an immediate, complete, and sustained C5 inhibition in all patients. Complete thrombotic microangiopathy response was achieved in 53.6% of patients. The median duration of Complete TMA Response was 7.97 months (range: 2.52 to 16.69 months). Other endpoints included platelet count change from baseline, dialysis requirement, and renal function as evaluated by estimated glomerular filtration rate (eGFR). Normalization of platelet count, lactate dehydrogenase and 25% or more improvement in serum creatinine was achieved in 83.9%, 76.8% and 58.9% of patients, respectively. Improvement in estimated glomerular filtration rate by one or more stage was achieved in 68.1% of patients by day 183. An increase in mean platelet count was observed after commencement of Ultomiris, increasing from 118.52 × 109 /L at baseline to 240.34 ×109 /L at Day 8 and remaining above 227 × 109 /L at all subsequent visits in the Initial Evaluation Period (26 weeks). Renal function, as measured by eGFR, was improved, or maintained during Ultomiris therapy. The mean eGFR (±SD) increased from 15.86 (14.82) at baseline to 51.83 (39.16) by 26 weeks. In patients with Complete TMA Response, renal function continued to improve after the Complete TMA Response was achieved. Seventeen of the 29 patients (59%) who required dialysis at study entry discontinued dialysis by the end of the available follow-up and 6 of 27 (22%) patients were off dialysis at baseline were on dialysis at last available follow-up. No unexpected adverse events were reported across a safety analysis set of 58 patients. Four deaths occurred (three within one month of study initiation, including one in a patient excluded based on eligibility criteria after the first dose) with none considered treatment-related by the study investigator.

Paroxysmal Nocturnal Hemoglobinuria (PNH)

Crovalimab is indicated for the treatment of paroxysmal nocturnal hemoglobinuria (PNH).

Ravulizumab is indicated for the treatment of paroxysmal nocturnal hemoglobinuria (PNH).

The safety and efficacy of Ultomiris in adult patients with PNH was assessed in two open-label, randomized, active-controlled, non-inferiority Phase 3 studies: PNH Study 301 and PNH Study 302. Study 301 enrolled patients with PNH who were complement inhibitor naïve and had active hemolysis. Study 302 enrolled patients with PNH who were clinically stable after having been treated with eculizumab for at least the past 6 months. Lee et al. evaluated the safety and

efficacy of Ultomiris in PNH Study 301, a 26-week, multicenter, open-label, randomized, active-controlled, non-inferiority Phase 3 study conducted in 246 patients naïve to complement inhibitor treatment prior to study entry.[14] Patients with lactate dehydrogenase (LDH) ≥ 1.5 times the upper limit of normal and at least 1 PNH symptom were randomized 1:1 to receive ravulizumab or eculizumab for 183 days. Ultomiris was dosed intravenously in accordance with a weight-based dosing schedule (4 infusions of Ultomiris over 26 weeks). Eculizumab was administered on Days 1, 8, 15, and 22, followed by maintenance treatment with 900 mg of eculizumab on Day 29 and every 2 weeks (q2w) thereafter for a total of 26 weeks of treatment, according to the approved dosing regimen of eculizumab which was the standard-of-care for PNH at the time of the studies. Ninety-eight percent of patients had a documented PNH-associated condition diagnosed prior to enrollment on the trial: anemia (85%), hemoglobinuria (63%), history of aplastic anemia (32%), history of renal failure (12%), myelodysplastic syndrome (5%), pregnancy complications (3%), and other (16%). Patients either were vaccinated against meningococcal infection prior to or at the time of initiating treatment with Ultomiris or eculizumab or received prophylactic treatment with appropriate antibiotics until 2 weeks after vaccination. Prophylactic treatment with appropriate antibiotics beyond 2 weeks after vaccination was at the discretion of the provider. Coprimary efficacy end points were proportion of patients remaining transfusion-free and LDH normalization. Secondary end points were percent change from baseline in LDH, change from baseline in Functional Assessment of Chronic Illness Therapy (FACIT)-Fatigue score, proportion of patients with breakthrough hemolysis, stabilized hemoglobin, and change in serum free C5. Ravulizumab was noninferior to eculizumab for both coprimary and all key secondary end points (Pinf < .0001): transfusion avoidance [73.6% vs. 66.1%; difference of 6.8% (95% confidence interval {CI}, -4.66, 18.14)], LDH normalization [53.6% vs. 49.4%; odds ratio, 1.19 (0.80, 1.77)], percent reduction in LDH [76.8% vs. -76.0%; difference (95% CI), -0.83% (-5.21, 3.56)], change in FACIT-Fatigue score [7.07 vs. 6.40; difference (95% CI), 0.67 (-1.21, 2.55)], breakthrough hemolysis [4.0% vs. 10.7%; difference (95% CI), -6.7% (-14.21, 0.18)], and stabilized hemoglobin [68.0% vs. 64.5%; difference (95% CI), 2.9 (-8.80, 14.64)]. There was no observable difference in fatigue between Ultomiris and eculizumab after 26 weeks of treatment compared to baseline as measured by the FACIT-fatigue instrument. The most frequently reported AE was headache (36.0% and 33.1% in the ravulizumab and eculizumab groups, respectively). Twenty patients experienced serious AEs (11 ravulizumab and 9 eculizumab patients); pyrexia was the only serious AE reported in > 1 patient (1 ravulizumab patient and 2 eculizumab patients). No cases of meningococcal infections, Aspergillus infections, or sepsis were reported. Other serious infections occurred in 2 patients (1.6%) in the ravulizumab group and 4 (3.3%) in the eculizumab group. Serious infections observed in patients treated with ravulizumab included leptospirosis and systemic infection (causative agents not identified); serious infections observed in patients treated with eculizumab included limb abscess, cellulitis, infection, pneumonia, and viral upper respiratory tract infection (causative agents not identified).

In 2021, Hillmen et al. evaluated the efficacy and safety of pegcetacoplan as compared to eculizumab in adults with PNH and hemoglobin levels below 10.5g/dL despite use of eculizumab for at least 3 months in a phase 3 open label, controlled trial (PEGASUS). All patients received pegcetacoplan plus eculizumab during a 4-week run-in phase, then randomized in a 1:1 ratio to subcutaneous pegcetacoplan monotherapy (n = 41) or intravenous eculizumab (n = 39) for 16 weeks. This period was followed by a 32-week period in which all patients received open-label pegcetacoplan. The primary endpoint was the mean change in hemoglobin level from baseline to week 16. Secondary endpoints include proportion of patients that did not require transfusion during the randomized, controlled period, change from baseline to week 16 in absolute reticulocyte count, lactate dehydrogenase (LDH) level, and score on the Functional Assessment of Chronic Illness Therapy-Fatigue (FACIT-F) scale. Clinical efficacy analysis found that pegcetacoplan was superior to eculizumab with respect to the change in hemoglobin level from baseline to week 16 with a mean difference between treatments of 3.84 g/dL [95% confidence interval (CI), 2.33 to 5.34; p < 0.001], with the increase of hemoglobin levels in patients receiving pegcetacoplan monotherapy seen as early as week 2 of the 16-week controlled trial period and maintained throughout the 16-week period. Additionally, 35 patients (85%) in the pegcetacoplan group were transfusion-free, whereas only 6 (15%) in the eculizumab group were transfusion-free (p < 0.001). FACIT-F scores increased with pegcetacoplan by 9.2 points and decreased with eculizumab by 2.7 points [adjusted mean difference of 11.9 points (95% CI, 5.49 to 18.25) at week 16]. 73% of patients in the pegcetacoplan group had at least a 3-point increase in FACIT-F scores at week 16, as compared with 0% in the eculizumab group (a 3-point change is considered clinically significant). Noninferiority of pegcetacoplan to eculizumab was shown for the change in absolute reticulocyte count. The researchers concluded that in patients with persistent anemia despite eculizumab therapy, pegcetacoplan was superior to eculizumab with respect to change in baseline hemoglobin levels and improvements in key clinical and hematologic variables, such as decrease in transfusions, and therefore treatment with pegcetacoplan may result in better control of PNH than treatment with eculizumab.[34]

The safety and efficacy of crovalimab for the treatment of PNH was demonstrated in an active-controlled, open-label, non-inferiority COMMODORE 2 study (NCT04434092). Patients with PNH were randomized in a 2:1 ratio to receive either crovalimab or eculizumab. An additional 6 pediatric patients received crovalimab in a separate non-randomized cohort. An initial loading dose of crovalimab was given on day 1 (1,000 mg for those ≥ 40 kg to < 100 kg, or 1,500 mg for patients weighing ≥ 100 kg), followed by four additional weekly subcutaneous loading doses of 340 mg starting on day 2. On day 29, maintenance dosing was started, given every 4 weeks (680 mg for patients weighing ≥ 40 kg to < 100 kg, or 1,020 mg

for patients weighing ≥ 100 kg). The treatment period was for 24 weeks, after which patients had the option to continue their current therapy or switch to crovalimab in an extension period. Efficacy of therapy was measured by hemolysis control, based on the mean proportion of patients with LDH ≤ 1.5x ULN from week 5 to week 25, as well as the proportion of patients who avoided transfusion (defined as those who were pRBC transfusion-free, from baseline through week 25). Secondary efficacy endpoints included the proportion of patients with breakthrough hemolysis (defined as at least one new or worsening symptom or sign of intravascular hemolysis in the presence of elevated LDH ≥ 2x ULN after prior reduction of LDH to ≤ 1.5x ULN on treatment) and the proportion of patients with stabilized hemoglobin (defined as avoidance of a ≥ 2 g/dL decrease in hemoglobin level from baseline, in the absence of transfusion). The difference in proportion of patients with transfusion avoidance, % (95% CI), between the crovalimab group and eculizumab was -2.8 (-15.7, 11.1). The mean proportion of patients achieving hemolysis control in the PiaSky group was 65.7 (56.9, 73.5) and 68.1 (55.7, 78.5) in the eculizumab group with an odds ratio, (95% CI), of 1.02 (0.57, 1.82). The proportion of patients with breakthrough hemolysis, % (95% CI), was 10.4 (6.0, 17.2) in the crovalimab arm and 14.5 (7.5, 25.5) in the eculizumab arm, a difference in proportions, % (95% CI), of - 3.9 (-14.8, 5.3). The proportion of patients with stabilized hemoglobin, % (95% CI), was 63.4 (54.6, 71.5) for crovalimab and 60.9 (48.4, 72.2) for eculizumab with a difference in proportions, % (95% CI), of 2.2 (-11.4, 16.3). In the pediatric arm, the treatment effect of crovalimab in pediatric patients with PNH was consistent with that observed in adults with PNH.[43]

Generalized Myasthenia Gravis

Ravulizumab is indicated for the treatment of generalized myasthenia gravis.

Vu et al. completed a phase 3, randomized, double-blind, placebo-controlled, multicenter study (CHAMPION MG) that evaluated the safety and efficacy of ravulizumab in complement-inhibitor-naïve patients 18 years of age and older, with a confirmed diagnosis of generalized myasthenia gravis. Patients were required to be classified by the Myasthenia Gravis Foundation of America as Class II to IV at screening, and a Myasthenia Gravis-Activities of Daily Living (MG-ADL) scale ≥ 6 at screening and randomization, and vaccination against Neisseria meningitidis. One hundred seventy-five patients were randomized to receive either placebo (n = 89), or ravulizumab (n = 86). Ravulizumab dosing was based on the patient's body weight: patient weight ≥ 40 kg to < 60 kg: 2,400 mg loading dose, 3,000 mg maintenance dose; weight ≥ 60 kg to < 100 kg: 2,700 mg loading dose, 3,300 mg maintenance dose; weight ≥ 100 kg, 3,000 mg loading dose, 3,600 mg maintenance dose. Patients received an initial loading dose of ravulizumab (2,400, 2,700, or 3,000 mg) or placebo at baseline (day 1), followed by maintenance doses of ravulizumab (3,000, 3,300, or 3,600 mg) or placebo on day 15 (week 2) and every 8 weeks thereafter. The primary outcome measure was the change in MG-ADL total score from baseline at week 26 as compared to placebo. A clinical response in MG-ADL was defined as at least a 3-point improvement. In this study, the primary end point (change from baseline in MG-ADL total score at 26 weeks) was statistically significantly improved with ravulizumab compared with placebo (-3.1 vs. -1.4; p < 0.001). There were two deaths in the ravulizumab group: one due to Covid-19 and one attributable to cerebral hemorrhage. There were no cases of meningococcal infection. No notable differences in adverse events between the two groups were observed. The most frequent adverse event was headache, experienced by 16 patients (19%) in the ravulizumab group and 23 (26%) in the placebo group. The other most common adverse reactions (≥ 10%) were diarrhea and upper respiratory tract infection. Serious adverse events were reported for 20 patients (23%) in the ravulizumab group and 14 (16%) in the placebo group. The most frequent serious adverse events were related to worsening of MG (one patient receiving ravulizumab and three receiving placebo) and Covid-19 (two receiving ravulizumab and one receiving placebo). A treatment effect, including improvement in clinical and functional outcomes, was observed within the first week of treatment and sustained throughout the 26-week randomized trial period. The difference between ravulizumab and placebo was statistically significant for the primary end point, despite a notable placebo effect. The authors stated that the influence of the Covid-19 pandemic was an important limitation to this study. Although mitigation measures allowed the trial to continue collecting data per trial design, it is undetermined how the pandemic may have affected assessments, particularly those related to health-related quality of life (HR-QoL).

Neuromyelitis Optica Spectrum Disorder (NMOSD)

Ravulizumab is indicated for the treatment of NMOSD.

Pittock et al. conducted a phase 3, open-label, externally controlled interventional study (CHAMPION-NMOSD) (NCT04201262) evaluating the efficacy and safety of ravulizumab in adult patients with anti–aquaporin-4 antibody–positive (AQP4+) neuromyelitis optica spectrum disorder (NMOSD). Ravulizumab binds the same complement component 5 epitope as the approved therapeutic eculizumab but has a longer half-life, enabling an extended dosing interval (8 vs 2 weeks). The availability of eculizumab precluded the use of a concurrent placebo control in CHAMPION-NMOSD; consequently, the placebo group of the eculizumab phase 3 trial PREVENT (n = 47) was used as an external comparator. Patients received weight-based intravenous ravulizumab on day 1 and maintenance doses on day 15, then once every 8 weeks. The primary endpoint was time to first adjudicated on-trial relapse. The primary endpoint was met; no patients

taking ravulizumab (n = 58) had an adjudicated relapse (during 84.0 patient-years of treatment) versus 20 patients with adjudicated relapses in the placebo group of PREVENT (during 46.9 patient-years; relapse risk reduction = 98.6%, 95% confidence interval = 89.7%-100.0%, p < 0.0001). Median (range) study period follow-up time was 73.5 (11.0-117.7) weeks for ravulizumab. Most treatment-emergent adverse events were mild/moderate; no deaths were reported. Two patients taking ravulizumab experienced meningococcal infections. Both recovered with no sequelae; one continued ravulizumab treatment.

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

PiaSky (crovalumab-akkz) is a complement inhibitor indicated for the treatment of adult and pediatric patients 13 years and older with paroxysmal nocturnal hemoglobinuria (PNH) and body weight of at least 40 kg.

The use of PiaSky increases the risk of serious and life-threatening infections caused by Neisseria meningitidis.
- Complete or update meningococcal vaccination at least 2 weeks prior to the first dose of PiaSky unless the risks of delaying PIASKY outweigh the risks of developing a serious infection. Comply with the most current Advisory Committee on Immunization Practices (ACIP) recommendations for meningococcal vaccination in patients receiving a complement inhibitor.
- Patients receiving PiaSky are at increased risk for invasive disease caused by N. meningitidis, even if they develop antibodies following vaccination. Monitor patients for early signs of meningococcal infections and evaluate immediately if infection is suspected.

Ultomiris (ravulizumab-cwvz) is a complement inhibitor indicated for:
- Treatment of adult and pediatric patients one month of age and older with paroxysmal nocturnal hemoglobinuria (PNH).
- Treatment of adult and pediatric patients one month of age and older with atypical hemolytic uremic syndrome (aHUS) to inhibit complement-mediated thrombotic microangiopathy (TMA).
- Treatment of adult patients with generalized Myasthenia Gravis (gMG) who are anti-acetylcholine receptor (AchR) antibody positive.
- Treatment of adult patients with neuromyelitis optica spectrum disorder (NMOSD) who are anti-aquaporin-4 (AQP4) antibody positive.

Limitations of Use: Ultomiris is not indicated for the treatment of patients with Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS).

The use of PiaSky and Ultomiris increases a patient's susceptibility to serious meningococcal infections (septicemia and/or meningitis). Meningococcal infection may become rapidly life-threatening or fatal if not recognized and treated early:
- Vaccinate for meningococcal disease according to the most current Advisory Committee on Immunization Practices (ACIP) recommendations for patients with complement deficiencies.
- Revaccinate patients in accordance with ACIP recommendations, considering the duration of Soliris therapy.
- Immunize patients without a history of meningococcal vaccination at least 2 weeks prior to receiving the first dose of Soliris or Ultomiris.
- If urgent therapy is indicated in an unvaccinated patient, administer meningococcal vaccine(s) as soon as possible.
- Closely monitor patients for early signs and symptoms of meningococcal infection and evaluate patients immediately if an infection is suspected.

PiaSky and Ultomiris are available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS). Under the REMS programs, prescribers must enroll in the program. Enrollment in the PiaSky REMS program and additional information are available by telephone: 1-866-469-7599 or at http://www.piaskyrems.com. Enrollment in the Ultomiris REMS programs and additional information are available by telephone: 1-888-765-4747 or at http://www.solirisrems.com or www.ultomirisrems.com.

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Policy History/Revision Information

Date	Summary of Changes
04/01/2026	**Coverage Rationale** • Revised coverage criteria for **Ultomiris** for: ***Generalized Myasthenia Gravis in Patients who are Anti-Acetylcholine Receptor (AChR) Antibody Positive*** ○ Added criterion requiring the patient is not receiving Ultomiris in combination with an immune globulin (e.g., Hizentra, Privigen, Gammagard) for treatment of the same indication

Date	Summary of Changes
	○ Replaced criterion requiring "the patient is not receiving Ultomiris in combination with *another* complement inhibitor [*e.g.,* Zilbrysq (Zilucoplan)] for treatment of the same indication" with "the patient is not receiving Ultomiris in combination with *a different* complement inhibitor [*i.e., Bkemv (eculizumab-aeeb), Epysqli (eculizumab-aagh), PiaSky (crovalimab), Soliris (eculizumab), Ultomiris (ravulizumab), or* Zilbrysq (Zilucoplan)] for treatment of the same indication" ○ Replaced reference to "*neonatal Fc receptor* blocker" with "*FcRN* blocker" ***Neuromyelitis Optica Spectrum Disorder (NMOSD)*** Initial Therapy ○ Removed criterion requiring one of the following: ▪ History of at least two relapses during the previous 12 months prior to initiating Ultomiris ▪ History of at least three relapses during the previous 24 months, at least one relapse occurring within the past 12 months prior to initiating Ultomiris **Applicable Codes** • Added HCPCS codes Q5151 and Q5152 • Removed HCPCS codes C9399, J3490, and J3590 **Supporting Information** • Updated *FDA* section to reflect the most current information • Archived previous policy version CSOH2025D0049.G

Instructions for Use

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