

UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1361-7
Program	Prior Authorization/Notification
Medication	Empaveli® (pegcetacoplan)
P&T Approval Date	7/2021, 7/2022, 8/2023, 2/2024, 4/2024, 4/2025, 10/2025
Effective Date	1/1/2026

1. Background:

Empaveli (pegcetacoplan) is a complement inhibitor indicated for the treatment of adult patients with paroxysmal nocturnal hemoglobinuria (PNH) and for the treatment of adult and pediatric patients aged 12 years and older with C3 glomerulopathy (C3G) or primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN), to reduce proteinuria.

2. Coverage Criteria^a:

A. Paroxysmal Nocturnal Hemoglobinuria (PNH)

1. Initial Authorization

a. **Empaveli** will be approved based on **both** of the following criteria:

(1) Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)

-AND-

(2) **One** of the following:

(a) Patient will not be prescribed Empaveli in combination with another complement inhibitor used for the treatment of PNH (e.g., Bkemy, Epysqli, Fabhalta, PiaSky, Soliris, Ultomiris)

-OR-

(b) Patient is currently receiving another complement inhibitor (e.g., Bkemy, Epysqli, Fabhalta, PiaSky, Soliris, Ultomiris) which will be discontinued and Empaveli will be initiated in accordance with the United States Food and Drug Administration approved labeling

Authorization will be issued for 12 months.

2. Reauthorization

a. **Empaveli** will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Empaveli therapy

-AND-

- (2) Patient is not receiving Empaveli in combination with another complement inhibitor used for the treatment of PNH (e.g., Bkemv, Epysqli, Fabhalta, PiaSky, Soliris, Ultomiris)

Authorization will be issued for 12 months.

B. C3 Glomerulopathy (C3G) or Primary Immune-Complex Membranoproliferative Glomerulonephritis (IC-MPGN)

1. Initial Authorization

- a. **Empaveli** will be approved based on **all** of the following criteria:

- (1) Diagnosis of **one** of the following:

- (a) C3 glomerulopathy (C3G)

-OR-

- (b) Primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN)

-AND-

- (2) Used to reduce proteinuria

-AND-

- (3) Patient is not receiving Empaveli in combination with another complement inhibitor used for the treatment of C3G or IC-MPGN (e.g., Bkemv, Epysqli, Fabhalta, PiaSky, Soliris, Ultomiris)

Authorization will be issued for 12 months.

2. Reauthorization

- a. **Empaveli** will be approved based on **both** of the following criteria:

- (1) Documentation of positive clinical response to Empaveli therapy demonstrated by a reduction in proteinuria

-AND-

- (2) Patient is not receiving Empaveli in combination with another complement inhibitor used for the treatment of C3G or IC-MPGN (e.g., Bkemv, Epysqli, Fabhalta, PiaSky, Soliris, Ultomiris)

Authorization will be issued for 12 months.

^a State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may also be in place.

4. References:

1. Empaveli [package insert], Waltham, MA: Apellis Pharmaceuticals, Inc.; July 2025.

Program	Prior Authorization/Notification - Empaveli® (pegcetacoplan)
Change Control	
7/2021	New program
7/2022	Annual review. Added state mandate with no other changes to coverage criteria.
8/2023	Annual review. Updated reference.
2/2024	Added Fabhalta to list of examples of other complement inhibitors used for the treatment of PNH. Revised initial authorization to 12 months. Included criteria for therapeutic duplication. Updated references.
4/2024	Simplified criteria language for converting to new complement inhibitor therapy.
4/2025	Annual review. No changes to coverage criteria. Updated examples of alternate complement inhibitors.
10/2025	Added criteria for new FDA-approved indications C3G and IC-MPGN. Updated background and references.