Neighborhood Health Plan OF RHODE ISLAND™
910 Douglas Pike, Smithfield, RI 02917 : 1-800-963-1001 : nhpri.org

Eculizumab: Soliris®; Bkemv™; Epysqli® Non-Hematology Policy (Intravenous)

Effective date: 01/01/2020

Dates Reviewed: 09/18/2019, 12/20/2019, 1/22/2020, 12/2020, 5/27/2021, 3/3/2022, 8/4/2022, 4/27/2023, 12/14/2023, 01/10/2024, 05/08/2024, 04/09/2025, 10/28/2025

Scope: Medicaid, Commercial, Medicare

For Hematology indications, please refer to the Neighborhood/Evolent Eculizumab Products Hematology Policy.

I. Length of Authorization

- gMG and NMOSD: Initial coverage will be provided for six (6) months and may be renewed every 6 months thereafter.

II. Dosing Limits

Max Units (per dose and over time) [HCPCS Unit]:

Indication	Loading Doses	Maintenance Dose (1 billable unit = 2 mg)
gMG, NMOSD	450 billable units (900 mg) Days 1, 8, 15, & 22; then 600 billable units (1200 mg) Day 29	600 billable units (1200 mg) every 14 days

III. Summary of Evidence

Eculizumab is a monoclonal antibody administered via intravenous infusion and approved for the treatment of multiple complement-mediated diseases. Soliris, Bkemv, Epysqli is indicated for the treatment of generalized myasthenia gravis (gMG) in adult and pediatric patients aged six years and older who are anti-acetylcholine receptor (AChR) antibody-positive, and Soliris for neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody-positive. Eculizumab binds with high affinity to complement protein C5, inhibiting its cleavage into C5a and C5b and preventing the

formation of the terminal complement complex C5b-9. In gMG, the presumed mechanism is reduction of terminal complement complex deposition and in NMOSD the presumed mechanism involves inhibition of AQ-4 antibody inducing terminal complement of C5b-9 deposition. In generalized myasthenia gravis, the efficacy of eculizumab was demonstrated in a 26-week, placebo-controlled trial (ECU-MG-301), where adult patients receiving eculizumab showed statistically significant improvements in clinical measures such as the MG-ADL (Myasthenia Gravis Activities of Daily Living) and QMG (Quantitative Myasthenia Gravis) scores compared to placebo. The most common adverse reaction observed in adults was musculoskeletal pain (15%). In NMOSD, a placebo-controlled trial (NMOSD Study 1) demonstrated that eculizumab significantly reduced the risk of relapse in AQP4 antibody-positive adults. Patients treated with eculizumab experienced a prolonged time to first relapse and a lower overall relapse rate compared to those receiving placebo. The most frequently reported adverse reactions in the NMOSD population included upper respiratory tract infections (29%), nasopharyngitis (21%), diarrhea (16%), back pain (15%), dizziness (15%), and influenza (11%). Eculizumab has a black box warning for serious meningococcal infections, a known risk with complement inhibitors, and requires careful management through prophylaxis vaccination and enrollment in a Risk Evaluation and Mitigation Strategy (REMS) program.

IV. Initial Approval Criteria [1-3]

Preferred Target Agent(s)	Non-Preferred Target Agent(s)
Epysqli (eculizumab-aagh)	Soliris (eculizumab) Bkemv (eculizumab-aeeb)

Coverage is provided in the following conditions:

Medicare members who have previously received this medication within the past 365 days are not subject to Step Therapy Requirements

Universal Criteria [1-3]

- Only one eculizumab product will be used; **AND**
- Will not be used in combination with other immunomodulatory biologic therapies [e.g., Rituxan (rituximab), Ultomiris (ravulizumab), Empaveli or Syfovre (pegcetacoplan), Enspryng (satralizumab), Uplizna (inebilizumab), Vyvgart (efgartigimod), Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase), Rystiggo (rozanolixizumab), Imaavy (nipocalimab), etc.]; **AND**
- The member does NOT have any FDA labeled contraindications to the requested agent; **AND**
- The requested quantity (dose) is within FDA labeled dosing for the requested indication

Generalized Myasthenia Gravis (gMG) † Φ [1,4-5,9-13]

- Submission of medical records (e.g., chart notes, laboratory values, etc.) to support the diagnosis of generalized myasthenia gravis (gMG); **AND**
- Member is at least 6 years of age; **AND**
- Prescribed by, or in consultation with a neurologist; **AND**

- Member has Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of Class II to IVb disease §; **AND**
- Member has a positive serologic test for anti-acetylcholine receptor (AChR) antibodies; **AND**
- Physician has assessed objective signs of neurological weakness and fatiguability on a baseline neurological examination [e.g., including, but not limited to, the Quantitative Myasthenia Gravis (QMG) score, etc.]; **AND**
- Member has a baseline MG-Activities of Daily Living (MG-ADL) total score of ≥6; **AND**
- The member's current medications have been assessed and any medications known to exacerbate myasthenia gravis (e.g., beta blockers, procainamide, quinidine, magnesium, anti-programmed death receptor-1 monoclonal antibodies, hydroxychloroquine, aminoglycosides) have been discontinued **OR** discontinuation of the offending agent is NOT clinically appropriate; **AND**
- The requested drug is a preferred agent (i.e., Epysqli) AND the member meets one of the following:
    - The member has tried and had an inadequate response to at least ONE conventional agent used for the treatment of myasthenia gravis (i.e., corticosteroids, azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, cyclophosphamide); OR
    - The member has an intolerance or hypersensitivity to ONE conventional agent used for the treatment of myasthenia gravis (i.e., corticosteroids, azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, cyclophosphamide); OR
    - The member has an FDA labeled contraindication to ALL conventional agents used for the treatment of myasthenia gravis (i.e., corticosteroids, azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, cyclophosphamide); OR
    - The member required chronic intravenous immunoglobulin (IVIG); OR
    - The member required chronic plasmapheresis/plasma exchange; AND
- The requested agent is a non-preferred agent (i.e., Bkemv, Soliris) AND the member meets ONE of the following:
    - The member has tried and had an inadequate response after at least a 1-year total trial to at least TWO immunosuppressive therapies (e.g., azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, cyclophosphamide) (either combination or monotherapy); **OR**
    - The member has an intolerance or hypersensitivity to at least TWO immunosuppressive therapies; **OR**
    - The member has tried and had an inadequate response after at least a 1-year total trial to treatment to at least ONE immunosuppressive therapy (e.g., azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, cyclophosphamide) AND ONE of the following:
        - The member required chronic intravenous immunoglobulin (IVIG) (i.e., at least every 3 months over 12 months without symptom control); **OR**
        - The member required chronic plasmapheresis/plasma exchange (i.e., at least every 3 months over 12 months without symptom control); **OR**
    - The member has an intolerance or hypersensitivity to at least ONE immunosuppressant AND plasmapheresis/plasma exchange; **OR**
    - The member has an FDA labeled contraindication to ALL immunosuppressive therapies and plasmapheresis/plasma exchange; **AND**
- If the requested agent is a non-preferred agent (i.e., Bkemv, Soliris), the member must have an inadequate response, intolerance/hypersensitivity or FDA-labeled contraindication to both

eculizumab-aagh (Epysqli) AND efgartigimod (Vyvgart IV or Vyvgart Hytrulo SC) that is not expected to occur with the requested agent [medical documentation must be provided]

§ Myasthenia Gravis Foundation of America (MGFA) Disease Clinical Classification [10]

- **Class I**: Any ocular muscle weakness; may have weakness of eye closure. All other muscle strength is normal.
- **Class II**: Mild weakness affecting muscles other than ocular muscles; may also have ocular muscle weakness of any severity.
  - **IIa**. Predominantly affecting limb, axial muscles, or both. May also have lesser involvement of oropharyngeal muscles.
  - **IIb**. Predominantly affecting oropharyngeal, respiratory muscles, or both. May also have lesser or equal involvement of limb, axial muscles, or both.
- **Class III**: Moderate weakness affecting muscles other than ocular muscles; may also have ocular muscle weakness of any severity.
  - **IIIa**. Predominantly affecting limb, axial muscles, or both. May also have lesser involvement of oropharyngeal muscles.
  - **IIIb**. Predominantly affecting oropharyngeal, respiratory muscles, or both. May also have lesser or equal involvement of limb, axial muscles, or both.
- **Class IV**: Severe weakness affecting muscles other than ocular muscles; may also have ocular muscle weakness of any severity.
  - **IVa**. Predominantly affecting limb, axial muscles, or both. May also have lesser involvement of oropharyngeal muscles.
  - **IVb**. Predominantly affecting oropharyngeal, respiratory muscles, or both. May also have lesser or equal involvement of limb, axial muscles, or both.
- **Class V**: Defined as intubation, with or without mechanical ventilation, except when employed during routine postoperative management. The use of a feeding tube without intubation places the member in class IVb.

Neuromyelitis Optica Spectrum Disorder (NMOSD) † Φ [1,6-8,14,15]

- Submission of medical records (e.g., chart notes, laboratory values, etc.) to support the diagnosis of neuromyelitis optica spectrum disorder (NMOSD) by a neurologist confirming all of the following:
  - Member is anti-aquaporin-4 (AQP4) antibody positive (lab test required); **AND**
  - The diagnosis was confirmed by at least 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**
    - The member has had at least ONE discrete clinical attack of CNS symptoms; **AND**
    - Alternative diagnoses (e.g., multiple sclerosis, ischemic optic neuropathy) have been ruled out; **AND**
- Prescribed by, or in consultation with, a neurologist; **AND**
- Member is at least 18 years of age; **AND**
- If the requested agent is a non-preferred agent (i.e., Soliris), the member must have an inadequate response, intolerance/hypersensitivity or FDA-labeled contraindication to Enspryng (satralizumab)*, Ultomiris (ravulizumab) AND Uplizna (inebilizumab) [medical documentation must be provided]

* This requirement **ONLY** applies to **Medicaid** Members

† FDA Approved Indication(s); **‡** Compendia Recommended Indication(s); **Φ** Orphan Drug

V. Renewal Criteria [1-3]

Coverage may be renewed based upon the following criteria:

- The member was previously approved for the requested agent through the plan's Medical Drug Review process (Note: members not previously approved for the requested agent will require initial evaluation review); **AND**
- Prescribed by, or in consultation with, a neurologist; **AND**
- Only one eculizumab product will be used; **AND**
- The member will NOT be using the requested agent in combination with other immunomodulatory biologic therapies [e.g., Rituxan (rituximab), Ultomiris (ravulizumab), Empaveli or Syfovre (pegcetacoplan), Enspryng (satralizumab), Uplizna (inebilizumab), Vyvgart (efgartigimod), Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase), Rystiggo (rozanolixizumab), Imaavy (nipocalimab), etc.]; **AND**
- The member does NOT have any FDA labeled contraindications to the requested agent; **AND**
- The requested quantity (dose) is within FDA labeled dosing for the requested indication; **AND**

Generalized Myasthenia Gravis (gMG)

- Submission of medical records (e.g., chart notes, laboratory tests) to demonstrate a positive clinical response from baseline as demonstrated by all of the following:
    - Improvement and/or maintenance of at least a 3-point improvement (i.e., reduction in score) from pre-treatment baseline in the Myasthenia Gravis-Specific Activities of Daily Living scale (MG-ADL) total score sustained for at least 4 weeks **Δ**; **AND**
    - Improvement in muscle strength testing with fatigue maneuvers as evidenced on neurologic examination when compared to baseline

*[**Δ** May substitute an improvement of at least 4-point from baseline in the Quantitative Myasthenia Gravis (QMG) total score sustained for at least 4-weeks, if available]*

Neuromyelitis Optica Spectrum Disorder (NMOSD)

- Submission of medical records (e.g., chart notes, laboratory tests) to demonstrate a 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 (e.g., reduced hospitalizations, improvement or stabilization of vision or paralysis)

VI. Dosage/Administration [1-3]

Indication	Dose*
Generalized Myasthenia Gravis (gMG) and Neuromyelitis Optica Spectrum Disorder (NMOSD)	**Adults** Loading dose: – 900 mg intravenously every 7 days for the first 4 weeks, followed by 1,200 mg intravenously for the fifth dose 7 days later Maintenance dose: – 1200 mg intravenously every 14 days **Pediatric members ≥ 6 years of age** 5 kg - <10 kg: – 300 mg weekly x 1 dose, 300 mg at week 2, then 300 mg every 3 weeks 10 kg - <20 kg: – 600 mg weekly x 1 dose, 300 mg at week 2, then 300 mg every 2 weeks 20 kg - <30 kg: – 600 mg weekly x 2 doses, 600 mg at week 3, then 600 mg every 2 weeks 30 kg - <40 kg: – 600 mg weekly x 2 doses, 900 mg at week 3, then 900 mg every 2 weeks ≥ 40 kg: – 900 mg weekly x 4 doses, 1200 mg at week 5, then 1200 mg every 2 weeks

**Doses should be administered at the above intervals, or within two days of these time points.*

VII. Billing Code/Availability Information

HCPCS Code(s):

- J1299 – Injection, eculizumab, 2mg; 1 billable unit = 2 mg *(Soliris ONLY) (Effective 04/01/2025)*
- Q5151 – Injection, eculizumab-aagh (epysqli), biosimilar, 2 mg; 1 billable unit = 2 mg (*Epysqli ONLY) (Effective 04/01/2025)*
- Q5152 – Injection, eculizumab-aeeb (bkemv), biosimilar, 2 mg; 1 billable unit = 2 mg *(Bkemv ONLY) (Effective 04/01/2025)*

NDC(s):

- Soliris 300 mg/30 mL single-dose vial for injection: 25682-0001-xx
- Bkemv 300 mg/30 mL single dose vial for injection: 55513-0180-xx
- Epysqli 300 mg/30 mL single dose vial for injection: 71202-0010-xx

VIII. References

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2. Bkemv [package insert]. Thousand Oaks, CA; Amgen Inc.; May 2024. Accessed July 2025.
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15. Kümpfel T, Giglhuber K, Aktas O, et al. Neuromyelitis Optica Study Group (NEMOS). 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. J Neurol. 2023 Sep 7. doi: 10.1007/s00415-023-11910-z. Epub ahead of print.
16. National Government Services, Inc. Local Coverage Article: Billing and Coding: Eculizumab (A54548). Centers for Medicare & Medicaid Services, Inc. Updated 09/09/2022 with effective date 10/01/2022. Accessed April 2024.

Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
G36.0	Neuromyelitis optica [Devic]
G70.00	Myasthenia gravis without (acute) exacerbation
G70.01	Myasthenia gravis with (acute) exacerbation

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

The preceding information is intended for non-Medicare coverage determinations. Medicare coverage for outmember (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15,

§50 Drugs and Biologicals. In addition, National Coverage Determinations (NCDs) and/or Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. Local Coverage Articles (LCAs) may also exist for claims payment purposes or to clarify benefit eligibility under Part B for drugs which may be self-administered. The following link may be used to search for NCD, LCD, or LCA documents: https://www.cms.gov/medicare-coverage- database/search.aspx. Additional indications, including any preceding information, may be applied at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes		
Jurisdiction	**NCD/LCA/LCD Document (s)**	**Contractor**
6, K	A54548	National Government Services, Inc

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC

Policy Rationale:
Eculizumab was reviewed by the Neighborhood Health Plan of Rhode Island Pharmacy & Therapeutics (P&T) Committee. Neighborhood adopted the following clinical coverage criteria to ensure that its members use eculizumab according to Food and Drug Administration (FDA) approved labeling and/or relevant clinical literature. Neighborhood worked with network prescribers and pharmacists to draft these criteria. These criteria will help ensure its members are using this drug for a medically accepted indication, while minimizing the risk for adverse effects and ensuring more cost-effective options are used first, if applicable and appropriate. For Medicare members, these coverage criteria will only apply in the absence of National Coverage Determination (NCD) or Local Coverage Determination (LCD) criteria. Neighborhood will give individual consideration to each request it reviews based on the information submitted by the prescriber and other information available to the plan.