Clinical Policy: Crovalimab-akkz (PiaSky)

Reference Number: CP.PHAR.664
Effective Date: 06.20.24
Last Review Date: 02.24
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

Crovalimab (PiaSky®) is a complement C5 inhibitor.

FDA Approved Indication(s)

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

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 PiaSky is **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 ≥ 13 years;
4. Body weight ≥ 40 kg;
5. Flow cytometry shows detectable glycosylphosphatidylinositol (GPI)-deficient hematopoietic clones or ≥ 10% PNH cells;
6. Failure of a ≥ 3-month trial of Soliris® or Ultomiris® up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
   **Prior authorization may be required for Soliris and Ultomiris*
7. PiaSky is not prescribed concurrently with another FDA-approved product for PNH (e.g., Bkemv™, Epysqli™, Soliris, Ultomiris, Empaveli®, Fabhalta®, Voydeya™);
8. Documentation of member's current body weight (in kg);
9. Dose does not exceed the following (a, b, c, and d):
   a. IV loading dose on Day 1 (i or ii):
      i. Weight ≥ 40 to < 100 kg: 1,000 mg;
      ii. Weight ≥ 100 kg: 1,500 mg;
   b. SC loading doses starting Day 2: 340 mg every week;
   c. SC maintenance doses starting Day 29 (i or ii):
      i. Weight ≥ 40 to < 100 kg: 680 mg every 4 weeks;
      ii. Weight ≥ 100 kg: 1,020 mg every 4 weeks;

d. If member is switching therapy from Soliris/Bkemv/Epysqli or Ultomiris, administration of the IV loading dose should occur at the time of the next scheduled C5 inhibitor dose.

Approval duration: 6 months

B. 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 (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 – f):
   a. Improved measures of intravascular hemolysis (e.g., normalization of lactate dehydrogenase [LDH]);
   b. Reduced need for red blood cell transfusions;
   c. Increased or stabilization of hemoglobin levels;
   d. Less fatigue;
   e. Improved health-related quality of life;
   f. Fewer thrombotic events;
3. Documentation of member's current body weight (in kg);
4. PiaSky is not prescribed concurrently with another FDA-approved product for PNH (e.g., Bkemv, Epysqli, Soliris, Ultomiris, Empaveli, Fabhalta, Voydeya);
5. If request is for a dose increase, new dose does not exceed one of the following (a or b):
   a. Weight ≥ 40 to < 100 kg: 680 mg SC every 4 weeks;

b. Weight ≥ 100 kg: 1,020 mg SC every 4 weeks.

Approval duration: 6 months

B. 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.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
GPI: glycosyl phosphatidylinositol
IV: intravenous
LDH: lactate dehydrogenase
PNH: paroxysmal nocturnal hemoglobinuria
SC: subcutaneous

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
Soliris (eculizumab)	**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
Ultomiris (ravulizumab-cwvz)	**IV dosing:** Day 1: Loading dose IV	IV: 3,600 mg/ 8 weeks

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	Day 15 and thereafter: Maintenance dose IV. If currently receiving SC Ultomiris, administer IV Ultomiris maintenance dose starting 1 week after last SC Ultomiris maintenance dose **Body Weight Range (kg) / Loading Dose (mg) / Maintenance Dose (mg)** ≥ 5 to < 10 / 600 / 300 every 4 weeks ≥ 10 to < 20 / 600 / 600 every 4 weeks ≥ 20 to < 30 / 900 / 2,100 every 8 weeks ≥ 30 to < 40 / 1,200 / 2,700 every 8 weeks ≥ 40 to < 60 / 2,400 / 3,000 every 8 weeks ≥ 60 to < 100 / 2,700 / 3,300 every 8 weeks ≥ 100 / 3,000 / 3,600 every 8 weeks **SC dosing** (maintenance only for age ≥ 18 years and weight ≥ 40 kg): 490 mg SC per week, starting 2 weeks after IV Ultomiris loading dose or 8 weeks after last IV Ultomiris maintenance dose	SC: 490 mg/week

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.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): unresolved serious *Neisseria meningitidis* infection, hypersensitivity to crovalimab or any of the excipients
- Boxed warning(s): serious meningococcal infections

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
PNH	**Body weight ≥ 40 kg to < 100 kg:** Day 1: 1,000 mg IV Day 2, 8, 15, and 22: 340 mg SC Day 29 and every 4 weeks thereafter: 680 mg SC **Body weight ≥ 100 kg:** Day 1: 1,500 mg IV Day 2, 8, 15, and 22: 340 mg SC Day 29 and every 4 weeks thereafter: 1,020 mg SC	See regimen

VI. Product Availability

Single-dose vial: 340 mg/2 mL

VII. References

1. PiaSky Prescribing Information. South San Francisco, CA: Genentech, Inc.; June 2024. Available at: https://www.gene.com/download/pdf/piasky_prescribing.pdf. Accessed June 26, 2024.
2. 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.
3. 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: 211–23
4. ClinicalTrials.gov. NCT04432584. A study evaluating the safety, pharmacokinetics, and efficacy of crovalimab versus eculizumab in participants with paroxysmal nocturnal hemoglobinuria (PNH) currently treated with complement inhibitors (COMMODORE 1). Available at: https://clinicaltrials.gov/study/NCT04432584. Accessed June 26, 2024.
5. ClinicalTrials.gov. NCT04434092. A phase III study evaluating the efficacy and safety of crovalimab versus eculizumab in participants with paroxysmal nocturnal hemoglobinuria (PNH) not previously treated with complement inhibitors. (COMMODORE 2). Available at: https://clinicaltrials.gov/study/NCT04434092. Accessed June 26, 2024.
6. ClinicalTrials.gov. NCT04654468. A study evaluating the efficacy, safety, pharmacokinetics, and pharmacodynamics of crovalimab in participants with paroxysmal nocturnal hemoglobinuria (PNH) not previously treated with complement inhibition (COMMODORE 3). Available at: https://clinicaltrials.gov/study/NCT04654468. Accessed June 26, 2024.

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
J1307	Injection, crovalimab-akkz, 10 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created pre-emptively	11.28.23	02.24
RT4: Drug is now FDA approved - criteria updated per FDA labeling: modified criteria to require age ≥ 13 years and body weight ≥ 40 kg, added documentation of member's current body weight, added criterion that members switching therapy from another C5 must administer dose at the time of next scheduled C5 inhibitor dose, clarified dose maximum to include only SC maintenance doses in the continued therapy section; references reviewed and updated.	06.26.24	
HCPCS code added [J1307] and removed codes [C9399, J3590].	11.07.24	

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.