Eculizumab (Soliris, Bkmev, Epysqli) injection, for intravenous use

Policy Number: MC/PC 009
Effective Date: August 1, 2025

Instructions for Use

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Related Policies

- n/a

Coverage Rationale

This policy refers to the following eculizumab products for intravenous infusion only:

- Soliris (eculizumab) injection, for intravenous use
- Bkemv (eculizumab-aeeb) injection, for intravenous use
- Epysqli (eculizumab-aagh) injection, for intravenous use

Atypical Hemolytic Uremic Syndrome

For initial coverage of eculizumab injection for Atypical Hemolytic Uremic Syndrome (aHUS), the following will be required:

- Diagnosis of atypical hemolytic uremic syndrome (aHUS) **and**
- Prescribed by or in consultation with one of the following:
  - Hematologist
  - Nephrologist

For reauthorization coverage of eculizumab injection for Atypical Hemolytic Uremic Syndrome (aHUS), the following will be required:

- Patient demonstrates positive clinical response (e.g., increase in mean platelet counts, hematologic normalization) to therapy

Generalized Myasthenia Gravis

For initial coverage of eculizumab injection for Generalized Myasthenia Gravis (gMG), the following will be required:

- Diagnosis of generalized myasthenia gravis (gMG) **and**
- Patient is anti-acetylcholine receptor (AChR) antibody positive **and**

- Patient is 6 years of age or older **and**
- One of the following:
    - For patients between 6 and 17 years of age, trial and failure, contraindication, or intolerance to one of the following:
        - immunosuppressive therapies (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus),
        - Chronic plasmapheresis or plasma exchange (PE)
        - Intravenous immunoglobulin (IVIG) **or**
    - For patients 18 years of age or older, one of the following:
        - Trial and failure, contraindication, or intolerance to two immunosuppressive therapies (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus) **or**
    - Both of the following:
        - Trial and failure, contraindication, or intolerance to one immunosuppressive therapy (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus) **and**
        - Trial and failure, contraindication, or intolerance to one of the following:
            - Chronic plasmapheresis or plasma exchange (PE)
            - Intravenous immunoglobulin (IVIG) **and**
- Prescribed by or in consultation with a neurologist.

For reauthorization coverage of eculizumab injection for Generalized Myasthenia Gravis (gMG), the following will be required:

- Presence of positive clinical response to therapy

Neuromyelitis Optica Spectrum Disorder

For initial coverage of eculizumab injection for Neuromyelitis Optica Spectrum Disorder (NMOSD), the following will be required:

- Diagnosis of neuromyelitis optica spectrum disorder (NMOSD) **and**
- Patient is anti-aquaporin-4 (AQP4) antibody positive **and**
- Prescribed by or in consultation with one of the following:
    - Neurologist
    - Ophthalmologist

For reauthorization coverage of eculizumab injection for Neuromyelitis Optica Spectrum Disorder (NMOSD), the following will be required:

- Presence of positive clinical response to therapy.

Paroxysmal Nocturnal Hemoglobinuria

For initial coverage of eculizumab injection for Paroxysmal Nocturnal Hemoglobinuria (PNH), the following will be required:

- Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) **and**
- Prescribed by or in consultation with one of the following:
    - Hematologist
    - Oncologist

For reauthorization coverage of eculizumab injection for Paroxysmal No following will be required:

- Patient demonstrates positive clinical response (e.g., hemoglobin stabilization, decrease in the number of red blood cell transfusions) to therapy

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 the member specific benefit plan document 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
J1300	Injection, eculizumab, 10 mg
Q5151	Injection, eculizumab-aagh (Epysqli), biosimilar, 2 mg
Q5152	Injection, eculizumab-aeeb (Bkemv), biosimilar, 2 mg

ICD-10 Code	Description
D59.31	Infection-associated hemolytic-uremic syndrome
D59.32	Hereditary hemolytic-uremic syndrome
D59.39	Other hemolytic-uremic syndrome
D59.5	Paroxysmal nocturnal hemoglobinuria [Marchiafava-Micheli]
G36.0	Neuromyelitis optica [Devic]
G70.0	Myasthenia gravis
G70.00	Myasthenia gravis without (acute) exacerbation
G70.01	Myasthenia gravis with (acute) exacerbation
N00.6	Acute nephritic syndrome with dense deposit disease
N01.6	Rapidly progressive nephritic syndrome with dense deposit disease
N02.6	Recurrent and persistent hematuria with dense deposit disease
N03.6	Chronic nephritic syndrome with dense deposit disease
N04.6	Nephrotic syndrome with dense deposit disease
N07.6	Hereditary nephropathy, not elsewhere classified with dense deposit disease
T86.19	Other complication of kidney transplant

Background

Eculizumab is a monoclonal antibody indicated for the treatment of paroxysmal nocturnal hemoglobinuria (PNH), atypical hemolytic uremic syndrome (aHUS), anti-acetylcholine receptor antibody positive generalized myasthenia gravis, and anti-aquaporin-4 (AQP4) antibody positive neuromyelitis optica spectrum disorder (NMOSD) (*Clinical Pharmacology 2023).*

Eculizumab is designed to selectively block terminal complement activation. Eculizumab binds to the terminal complement protein C5 with high affinity, which inhibits its cleavage into C5a and C5b and prevents the generation of

the terminal complement complex C5b-9. A genetic mutation in patients with [illegible]a (PNH) causes the formation of abnormal red blood cells, which are deficient in [illegible] deficiency in terminal complement inhibitors causes the abnormal cells to be sensitive to lysis by terminal complements leading to intravascular hemolysis. In patients with PNH, eculizumab inhibits intravascular hemolysis mediated by terminal complements. Eculizumab inhibits complement-mediated thrombotic microangiopathy in patients with atypical hemolytic uremic syndrome. The presumed mechanism of action of eculizumab in generalized myasthenia gravis is the reduction of the terminal complement complex C5b-9 deposition at the neuromuscular junction. Eculizumab may inhibit aquaporin-4-antibody induced terminal complement C5b-9 deposition in neuromyelitis optica spectrum disorder *(Clinical Pharmacology 2023*).

Clinical Evidence

Paroxysmal Nocturnal Hemoglobinuria (PNH)

The efficacy and safety of eculizumab in adult patients with PNH were evaluated in a 26-week, Phase 3, multi-center (MC), double-blind (DB), placebo-controlled (PC), randomized controlled trial (RCT) (TRIUMPH), a 52-week, Phase 3, open-label (OL), single-arm trial (SHEPHERD), and a long-term extension study (*Brodsky et al 2008, Hillmen et al 2006, Hillmen et al 2013*). In the TRIUMPH study, patients with PNH who had received ≥ 4 transfusions during the previous year were randomized to receive eculizumab (n = 43) or placebo (n = 44). The coprimary endpoints were Hemoglobin (Hb) stabilization and the number of units of packed RBCs (PRBCs) transfused. Hb stabilization was achieved in 49% of eculizumab-treated patients vs 0 placebo-treated patients ($p < 0.001$). The median PRBC units transfused per patient was 0 for the eculizumab group vs 10 for the placebo group ($p < 0.001$). The overall rate of transfusion was reduced by 73% in the eculizumab group. Secondary endpoints, including transfusion independence, hemolysis as measured by lactate dehydrogenase (LDH) levels, and changes in level of fatigue as measured by the Functional Assessment of Chronic Illness Therapy-Fatigue (FACIT-Fatigue) instrument, all demonstrated statistically significant benefits with eculizumab (*Hillmen et al 2006*). In the OL, single-arm SHEPHERD trial, inclusion criteria were relaxed to allow the enrollment of patients with minimal need of transfusion support (≥ 1 transfusion in the previous 2 years). All patients (N = 97) receiving eculizumab had a substantial reduction in hemolysis as measured by levels of LDH. LDH was reduced from a mean of 2201 ± 105 U/L at baseline to 297 ± 21 U/L at 52 weeks ($p < 0.001$); hemolysis was also significantly reduced across all quartiles of baseline LDH levels and among patients with different baseline platelet counts (*Brodsky et al 2008*). Patients (n = 195) who had participated in TRIUMPH, SHEPHERD, or the Phase 2 pilot studies were eligible for enrollment in a long-term extension study. The entire period of eculizumab administration across the parent and extension trials was 66 months, although a 36-month cut-off was used for safety and efficacy assessments. Four patient deaths were reported, all unrelated to treatment, resulting in a 3-year Kaplan-Meier survival estimate of 97.6% (95% CI, 93.7 to 99.1). All patients showed a reduction in LDH levels (median reduction of 86.9% at 36 months), transfusion independence increased to 82.1% by the last 6 months of treatment vs 8.2% in the 6 months prior to the start of treatment, thrombotic events decreased by 81.8%, and patients showed a time-dependent improvement or stabilization in chronic kidney disease (CKD) score at 36 months (*Hillmen et al 2013*).

Atypical Hemolytic Uremic Syndrome (aHUS)

The efficacy of eculizumab for the treatment of aHUS has been evaluated in various patient populations in 26-week, OL, single-arm trials (*Fakhouri et al 2016, Greenbaum et al 2016, Legendre et al 2013*). Legendre et al enrolled patients ≥ 12 years of age with clinical evidence of progressing TMA (Trial 1; n = 17) and in disease of long duration, chronic kidney damage, and prolonged treatment with plasma exchange/infusion (PE/PI) (Trial 2; n = 20). Patients were evaluated for mean change in platelet count, thrombotic microangiopathy (TMA) event-free status, and normalization of hematologic values at Week 26 and during a long-term extension. For the primary endpoint in Trial 1, the mean change in platelet count from baseline was significant (difference, 73 x 109/L; 95% CI, 40 to 105; $p < 0.001$) although the difference in Trial 2 was not. For the primary endpoint in Trial 2, the TMA event-free status was achieved in 80% of patients. Eculizumab treatment was also associated with continuous, time-dependent increases in the estimated glomerular filtration rate (eGFR) from baseline to Week 26. In both trials, earlier initiation of eculizumab was associated with a significantly greater improvement in the eGFR throughout the treatment period (*Legendre et al 2013*). In a study of adult patients

with aHUS (n = 41), 73% achieved complete TMA response (defined as hemato of kidney function) at 26 weeks. TMA event-free status was achieved in 90% of pa on was achieved in 88%. eGFR improvement of ≥ 15 mL/min/1.73 m^2 was achieved in 32% of patients (*Fakhouri et al 2016*). Weight-based dosing of eculizumab was evaluated in pediatric patients (n = 22) ranging in age from 5 months to 17 years. Complete TMA response by 26 weeks, the primary endpoint, was achieved in 64% of patients. TMA event-free status was achieved in 95% of patients. Hematologic normalization occurred in 82% of patients. A decrease in serum creatinine (SCr) level by ≥ 25% occurred in 16 patients (73%); 19 patients (86%) had eGFR improvement ≥ 15 mL/min/1.73 m^2. Nine of 11 patients (82%) receiving dialysis at baseline discontinued dialysis during the study after a median of 7 days; of these, 1 discontinued dialysis before eculizumab initiation. All 11 patients not receiving baseline dialysis remained dialysis-free (*Greenbaum et al 2016*).

Generalized Myasthenia Gravis (gMG)

The efficacy of eculizumab in adults with anti-AChR antibody-positive refractory gMG was evaluated in a 26-week, Phase 3, double-blind (DB), multicenter (MC), placebo-controlled (PC), RCT. Patients who had been previously treated with immunosuppressive therapies or chronic IVIG or PE without symptom control were randomized to receive eculizumab (n = 62) or placebo (n = 63). Patients receiving previous treatment with a cholinesterase inhibitor, corticosteroid, or other immunosuppressive treatments were to maintain the dose and schedule of these therapies. For the primary endpoint, change from baseline to Week 26 in MG-ADL total score measured by worst-rank analysis of covariance (ANCOVA), the difference between groups in mean total score did not achieve statistical significance; however, in the responder analysis for the Myasthenia Gravis Activities of Daily Living (MG-ADL) and the quantitative myasthenia gravis (QMG) scores, a higher proportion of patients achieved a clinically meaningful response with eculizumab than with placebo (*Howard et al 2017*). The Institute for Clinical and Economic Review (ICER) evaluated the Phase 3 studies supporting eculizumab in the REGAIN study and efgartigimod alfa-fcab in the ADAPT study for the treatment of gMG (Howard et al 2017, Howard et al 2021, Tice et al 2021). Evidence supporting rituximab and IVIG were also reviewed. A network meta-analysis comparing eculizumab, efgartigimod alfa-fcab, and placebo at 4 weeks in patients with refractory anti-AChR antibody-positive gMG showed that both eculizumab and efgartigimod alfa-fcab significantly improved MG-ADL and QMG. At 4 weeks, efgartigimod alfa-fcab had significantly greater improvements compared with eculizumab. At 8 weeks, the results for efgartigimod alfa-fcab had returned to near baseline due to the dosing schedule and were lower than those for eculizumab. In adults with gMG positive for anti-AChR antibodies refractory to conventional therapy, ICER concluded that there is moderate certainty of a small or substantial net health benefit with high certainty of at least a small benefit for eculizumab added to conventional therapy compared to conventional therapy alone (Evidence Rating B+). There is moderate certainty of a comparable, small, or substantial net health benefit of efgartigimod alfa-fcab added to conventional therapy with high certainty of at least comparable net health benefit (Evidence Rating C++). Given uncertainties about dosing and long-term benefits and safety of efgartigimod alfa-fcab and the limitations of indirect comparisons, evidence was insufficient (Evidence Rating I) to distinguish the net health benefits of efgartigimod alfa-fcab from eculizumab. Evidence was insufficient (Evidence Rating I) to distinguish the net health benefits of rituximab and IVIG from placebo, eculizumab, and efgartigimod alfa-fcab. In adults with gMG negative for anti-AChR antibodies, ICER concluded that the evidence was insufficient (Evidence Rating I) to distinguish the net health benefits of efgartigimod alfa-fcab added to conventional therapy from conventional therapy alone.

Neuromyelitis Optica Spectrum Disorder (NMOSD)

The efficacy and safety of eculizumab for the treatment of NMOSD were evaluated in the Phase 3, double-blind (DB), placebo-controlled (PC), randomized PREVENT trial (*Pittock et al 2019*). The 143 adults with AQP4-IgG seropositive NMOSD with a mean baseline Expanded Disability Status Scale (EDSS) score of 4.00 were randomized to eculizumab 900 mg IV every week for 4 doses followed by eculizumab 1200 mg IV every 2 weeks or placebo until relapse or the end of the trial. Previous immunosuppressants, with the exception of rituximab, were continued in 76% of patients in the trial. The primary endpoint was the first adjudicated relapse, which was significantly lower in the eculizumab group (3/96; 3%) compared with the placebo group (20/47; 43%) (hazard ratio [HR], 0.06; 95% confidence interval [CI], 0.02 to 0.20; $p < 0.001$). The trial ended early after 23 adjudicated relapses rather than the planned 24 relapses since it was unknown when the final adjudicated relapse would occur. Discontinuation rate was higher in the eculizumab group (17% vs 6%). The adjudicated annualized relapse rate (ARR) was 0.02 and 0.35 for the eculizumab and placebo groups, respectively

(HR, 0.04; 95% CI, 0.01 to 0.15; p < 0.001). One death due pulmonary empyem up. The rate of serious adverse effects (AEs) was 27 and 55 per 100 patient-years (oups, respectively, with the exclusion of relapses.

Place in therapy

PNH: Although there are currently no U.S. consensus guidelines for the treatment of PNH, ravulizumab is preferred over eculizumab based on greater convenience and fewer episodes of pharmacokinetic breakthrough hemolysis, but otherwise, these agents have comparable efficacy and toxicity for patients with significant disease manifestations due to hemolysis. Allogeneic HCT is the only curative therapy for PNH and may be pursued for patients with severe cytopenias, patients with suboptimal disease response to complement inhibition, and patients who do not have access to a complement inhibitor (*Brodsky 2024).*

aHUS: Based on international consensus recommendations, all patients with a clinical diagnosis of aHUS should be treated with eculizumab as first-line therapy. Plasma therapy may be used if eculizumab is unavailable. Depending on patient and disease characteristics, immunosuppressant therapy with corticosteroids, cyclophosphamide, mycophenolate mofetil, and/or rituximab may be utilized. Certain patients may be candidates for kidney transplantation (*Goodship et al 2017, Loirat et al 2016*). Ravulizumab was FDA-approved in 2018 after these aHUS guidelines were released.

MG: International consensus guidance for the management of MG recommends pyridostigmine as initial symptomatic treatment in most patients with MG. Corticosteroids and/or other immunosuppressive therapy (e.g., azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus) may be used in patients who have not met treatment goals after an adequate trial of pyridostigmine. Patients with refractory MG may require chronic IVIG or PE, cyclophosphamide, or rituximab; complement inhibition with eculizumab should be considered in severe refractory MG (*Narayanaswami et al 2020*).

NMOSD: No U.S. based guidelines for NMOSD are available, and no guidelines are available that address the place in therapy for Eculizumab. NMO acute relapses are treated with high-dose corticosteroids followed by an oral prednisone taper over several months (*Kimbrough et al 2012, Sellner et al 2010, Trebst et al 2014*). The European Federation of Neurological Societies (EFNS) guideline for the prevention of NMO relapses recommends oral azathioprine plus prednisone or rituximab as first-line therapy (*Sellner et al 2010*). Other groups recommend mycophenolate mofetil plus prednisone as an additional first-line choice. Other treatment options include oral methotrexate, mitoxantrone, IV cyclophosphamide, IVIG, or PE (*Kimbrough et al 2012, Sellner et al 2010, Trebst et al 2014*).

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.

Soliris (eculizumab) is a complement inhibitor indicated for:

- The treatment of patients with paroxysmal nocturnal hemoglobinuria (PNH) to reduce hemolysis.
- The treatment of patients with atypical hemolytic uremic syndrome (aHUS) to inhibit complement-mediated thrombotic microangiopathy.
- The treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AchR) antibody positive.
- The treatment of neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive.

Bkemv (eculizumab-aeeb) is a complent inhibitor indicated for:

- The treatment of patients with paroxysmal nocturnal hemoglobinuria (PNH) to reduce hemolysis.

- The treatment of patients with atypical hemolytic uremic syndrome (aHUS thrombotic microangiopathy.
- The treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AchR) antibody positive.

Epysqli (eculizumab-aagh) is a complement inhibitor indicated for:

- The treatment of patients with paroxysmal nocturnal hemoglobinuria (PNH) to reduce hemolysis.
- The treatment of patients with atypical hemolytic uremic syndrome (aHUS) to inhibit complement-mediated thrombotic microangiopathy.
- The treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AchR) positive.

References

1. Bkemv [package insert]. Amgen. Thousand Oaks, CA. October 2024.
2. Brodsky RA, Young NS, Antonioli E, et al. Multicenter phase 3 study of the complement inhibitor eculizumab for the treatment of patients with paroxysmal nocturnal hemoglobinuria. Blood. 2008;111(4):1840-7.
3. Brodsky RA. Paroxysmal nocturnal hemoglobinuria: Treatment and prognosis. UpToDate Web site. Updated November 6, 2024. www.uptodate.com. Accessed January 22, 2025.
4. Eculizumab. Clinical Pharmacology powered by ClinicalKey. Philadelphia (PA): Elsevier; 2023. Available from: http://www.clinicalkey.com. Accessed January 22, 2025.
5. Epysqli [package insert]. Teva. Parsippany, NJ. April 2025.
6. Fakhouri F, Hourmant M, Campistol JM, et al. Terminal complement inhibitor eculizumab in adult patients with atypical hemolytic uremic syndrome: a single-arm open-label trial. Am J Kidney Dis. 2016;68(1):84-93.
7. Goodship TH, Cook HT, Fakhouri F, et al; Conference Participants. Atypical hemolytic uremic syndrome and C3 glomerulopathy: conclusions for a "Kidney Disease: Improving Global Outcomes" (KDIGO) Controversies Conference. Kidney Int. 2017;91(3):539-551.
8. Greenbaum LA, fila M, Ardissino G, et al. Eculizumab is a safe and effective treatment in pediatric patients with atypical hemolytic uremic syndrome. Kidney Int. 2016;89(3):701-11.
9. Hillmen P, Young NS, Schubert J, et al. The complement inhibitor eculizumab in paroxysmal nocturnal hemoglobinuria. N Engl J Med. 2006;355(12):1233-43.
10. Hillmen P, Muus P, Roth A, et al. Long-term safety and efficacy of sustained eculizumab treatment in patients with paroxysmal nocturnal haemoglobinuria. Br J Haematol. 2013;162(1):62-73.
11. Howard JF Jr, Utsugisawa K, Benatar M, et al. Safety and efficacy of eculizumab in anti-acetylcholine receptor antibody-positive refractory generalized myasthenia gravis (REGAIN): a phase 3, randomised, double-blind, placebo-controlled, multicentre study. Lancet Neurol. 2017;16(12):976-986.
12. Howard JF, Bril V, Karam C, et al for the ADAPT Investigator Study Group. Safety, efficacy, and tolerability of efgartigimod in patients with generalized myasthenia gravis (ADAPT): a multcentre, randomized, placebo-controlled, phase 3 trial. Lancet Neurol. 2021; 20:526-536.
13. Kimbrough DJ, Fujihara K, Jacob A, et al and the GJCF-CC&BR. Treatment of neuromyelitis optica: review and recommendations. Mult Scler Relat Disord. 2012;1(4):180-187.
14. Legendre CM, Licht C, Muus P, et al. Terminal complement inhibitor eculizumab in atypical hemolytic-uremic syndrome. New Engl J Med. 2013; 368:2169-2181
15. Loirat C, Fakhouri F, Ariceta G, et al; HUS International. An international consensus approach to the management of atypical hemolytic uremic syndrome in children. Pediatr Nephrol. 2016;31(1):15-39.

16. Narayanaswami P, Sanders DB, Wolfe G, et al. International consensus gui[illegible]a gravis. Neurology. 2021; 96:114-122.
17. Pittock SJ, Berthele A, Fujihara K, et al. Eculizumab in aquaporin-4-positive neuromyelitis optica spectrum disorder. N Engl J Med. 2019; 381:614-625.
18. Sanders DB, Wolfe GI, Benatar M, et al. International consensus guidance for management of myasthenia gravis: Executive summary. Neurology. 2016;87(4):419-425.
19. Sellner J, Boggild M, Clanet M, et al. EFNS guidelines on diagnosis and management of neuromyelitis optica. Eur J Neurol. 2010; 17:1019-1032.
20. Soliris [package insert], Boston, MA: Alexion Pharmaceuticals, Inc.; September 2024.
21. Tice JA, Touchette DR, Nikitin D, Campbell JD, Lien P-W, Moradi A, Rind DM, Pearson SD, Agboola F. Eculizumab and Efgartigimod for the Treatment of Myasthenia Gravis: Effectiveness and Value; Final Report. Institute for Clinical and Economic Review, September 10, 2021. https://icer.org/assessment/myasthenia-gravis/#timeline.
22. Trebst C, Jarius S, Berthele A, et al. Update on the diagnosis and treatment of neuromyelitis optica: recommendations of the Neuromyelitis Optica Study Group (NEMOS). J Neurol. 2014; 261:1-16. doi: 10.1007/s00415-013-7169-7.
23. Wingerchuk DM, Banwell B, Bennett JL, et al. International consensus diagnostic criteria for neuromyelitis optica spectrum disorders. Neurology. 2015; 85:177-189.

Policy History/Revision Information

Date	Summary of Changes
10/18/2023	Approved by OptumRx P&T Committee
2/15/2024	Annual Review. Changes to coverage rationale to remove dosing information
2/20/2025	Annual Review. Updated references. Updates to coverage rationale with no change to clinical intent.
7/16/2025	Addition of Bkmev & Epysqli, leading to change of name in policy. Updated language in coverage rationale section and updated references.

Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. The insurance reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

OptumRx may also use tools developed by third parties to assist us in administering health benefits. OptumRx Medical Benefit Drug Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Archived Policy Versions (Internal Only)

Effective Date	Policy Number	Policy Title
mm/dd/yyyy – mm/dd/yyyy	######	Title of Policy Hyperlinked to KL or Other Internal Location

Nondiscrimination & Language Access Policy

Discrimination is Against the Law. Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, (including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation, gender identity and sex stereotypes), consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2). Aspirus Health Plan, Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Aspirus Health Plan, Inc.:
Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters.
- Information written in other languages.

If *you* need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Nondiscrimination Grievance Coordinator at the address, phone number, fax number, or email address below.

If *you* believe that Aspirus Health Plan, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, *you* can file a *grievance* with:

Nondiscrimination Grievance Coordinator
Aspirus Health Plan, Inc.
PO Box 1890
Southampton, PA 18966-9998
Phone: 1-866-631-5404 (TTY: 711)
Fax: 763-847-4010
Email: customerservice@aspirushealthplan.com

You can file a *grievance* in person or by mail, fax, or email. If *you* need help filing a *grievance*, the Nondiscrimination Grievance Coordinator is available to help *you*.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. This notice is available at Aspirus Health Plan, Inc.'s website: https://aspirushealthplan.com/webdocs/70021-AHP-NonDiscrim_Lang-Assist-Notice.pdf.

Language Assistance Services

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë.Telefononi në 1-800-332-6501 (TTY: 711).

Arabic تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بن اعلى رقم الهاتف1-800-332-6501(رقم هاتف الصم والبك : 711)

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-332-6501 (ATS: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zurVerfügung. Rufnummer: 1-800-332-6501 (TTY: 711).

Hindi: _यान द_: य_द आप ि हंदी बोलते ह_ तो आपके ि लए मु_त म_ भाषा सहायता सेवाएं उपल_ध ह_।1-800-332-6501 (TTY: 711) पर कॉल कर_।

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-332-6501 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.1-800-332-6501 (TTY: 711)번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer1-800-332-6501 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.Звоните 1-800-332-6501 (телетайп: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al1-800-332-6501 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1-800-332-6501 (TTY: 711).

Traditional Chinese: 注意：如果您使用繁體中文， 您可以免費獲得語言援助服務。請 致電 1-800-332-6501 (TTY: 711)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-332-6501 (TTY: 711).

Pennsylvania Dutch: Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-332-6501 (TTY: 711).

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ,ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-332-6501 (TTY: 711).