PiaSky (crovalimab-akkz)

Disclaimer

Clinical guidelines are developed and adopted to establish evidence-based clinical criteria for utilization management decisions. Clinical guidelines are applicable according to policy and plan type. The Plan may delegate utilization management decisions of certain services to third parties who may develop and adopt their own clinical criteria.

Coverage of services is subject to the terms, conditions, and limitations of a member's policy, as well as applicable state and federal law. Clinical guidelines are also subject to in-force criteria such as the Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) for Medicare Advantage plans. Please refer to the member's policy documents (e.g., Certificate/Evidence of Coverage, Schedule of Benefits, Plan Formulary) or contact the Plan to confirm coverage.

Summary

Paroxysmal nocturnal hemoglobinuria (PNH) is a rare, acquired, life-threatening disease of the blood characterized by complement-mediated hemolysis, thrombosis, and bone marrow failure. Loss of the complement inhibitors, CD55 and CD59, on the surface of red blood cells leads to chronic and/or paroxysmal intravascular hemolysis and a predisposition for thrombosis. Complement inhibitors target this complement-mediated hemolysis inhibiting its cleavage.

PiaSky (crovalimab-akkz), is a complement C5 inhibitor and a humanized monoclonal antibody, 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.

Definitions

"Flow cytometry" is a tool used to rapidly assess the characteristics of a single cell using lasers in a buffered salt solution.

"Immunomodulatory biologics" are large molecule drugs used to change one's immune response.

Clinical Indications

Medical Necessity Criteria for Clinical Review

General Medical Necessity Criteria

The Plan considers PiaSky (crovalimab-akkz) medically necessary when ALL the following criteria are met:

1. The medication is prescribed by, or in consultation with a hematologist; *AND*
2. The member will not be used concomitantly with other immunomodulatory biologic therapies or complement inhibitors (e.g., eculizumab, ravulizumab, danicopan, iptacopan, pegcetacoplan, etc.), unless initially crosstitrating from another complement inhibitor; *AND*
3. Dosing is consistent with FDA-approved labeling OR is supported by compendia or evidence-based published dosing guidelines based on indication, weight, and age; *AND*
4. The member meets the medical necessity criteria for the applicable indication listed below.

Medical Necessity Criteria for Initial Clinical Review

Initial Indication-Specific Criteria

Paroxysmal Nocturnal Hemoglobinuria (PNH)

The Plan considers PiaSky (crovalimab-akkz) medically necessary when ALL the following criteria are met:

5. The member meets the above General Medical Necessity Criteria; *AND*
6. The member is 13 years of age or older; *AND*
7. The member has a body weight of at least 40 kg; *AND*

8. There is a diagnosis of PNH confirmed by flow cytometry demonstrating a deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs) with ONE of the following:
    a. at least 5% PNH cells (i.e., cells lacking GPI-AP expression); *or*
    b. at least 51% of GPI-deficient poly-morphonuclear cells (e.g., neutrophils deficient in GPI-APs); *AND*
9. The member has documentation of ONE of the following:
    a. Lactate dehydrogenase (LDH) > 1.5 x upper limit of normal (ULN)
    b. Hemoglobin ≤ 9 g/dL with symptomatic anemia, or hemoglobin ≤ 7 g/dL; *and/or*
    c. Absolute reticulocyte count ≥ 2 times the upper limit of normal; *and/or*
    d. Thrombosis; *and/or*
    e. Transfusion dependence (≥ 2 transfusions in the last 12 months).
10. The member is unable to use, or has tried and failed ONE of the following:
    a. Bkemv (eculizumab-aeeb); *or*
    b. Soliris (eculizumab); *or*
    c. Ultomiris (ravulizumab-cwvz).

If the above prior authorization criteria are met, the requested product will be authorized for up to 6-months.

Continued Care

Medical Necessity Criteria for Subsequent Clinical Review

Subsequent Indication-Specific Criteria

Paroxysmal Nocturnal Hemoglobinuria (PNH)

Reauthorization for PiaSky (crovalimab-akkz) will be granted if the member has recent (within the last 3 months) clinical chart documentation demonstrating ALL of the following criteria:

5. The member meets the above applicable General Medical Necessity Criteria; *AND*
6. There is no unacceptable toxicity or adverse reaction to therapy, such as:
    a. Serious infections (e.g. serious respiratory or urinary tract infections); *and/or*
    b. Severe hypersensitivity reactions; *and/or*
    c. Severe immunosuppression; *and/or*
    d. Other intolerable side effects or reactions; *AND*
7. Ongoing therapy is required to maintain disease stability and control; *AND*
8. Documentation of positive clinical response to therapy, including ONE of the following:
    a. Stabilization of hemoglobin levels; *and/or*
    b. Decreased transfusion requirements; *and/or*
    c. Reduced hemolysis; *and/or*
    d. Improvement in PNH symptoms; *and/or*
    e. Improvement or normalization of lactate dehydrogenase (LDH) levels.

If the above reauthorization criteria are met, the requested product will be authorized for up to 12-months.

Experimental or Investigational / Not Medically Necessary

PiaSky (crovalimab-akkz) for any other indication or use is considered not medically necessary by the Plan, as it is deemed to be experimental, investigational, or unproven. Non-covered indications include, but are not limited to, the following:

- Concomitant use with other targeted immunomodulating biologics (unless initially switching from another complement inhibitor).
- Other complement-mediated diseases or conditions not listed above as medically necessary.
- Use in patients who have unresolved serious *Neisseria meningitidis* infection or are not adequately vaccinated against *Neisseria meningitidis.*

Applicable Billing Codes

Table 1	
CPT/HCPCS codes for X service considered medically necessary if criteria are met:	
Code	*Description*
J1307	Injection, crovalimab-akkz, 10 mg

Table 2	
ICD-10 diagnosis codes considered medically necessary with Table 1 (CPT/HCPCS) codes if criteria are met:	
Code	*Description*
D59.5	Paroxysmal Nocturnal Hemoglobinuria [Marchiafava-Micheli]

References

1. Borowitz MJ, Craig F, DiGiuseppe JA, et al. Guidelines for the Diagnosis and Monitoring of Paroxysmal Nocturnal Hemoglobinuria and Related Disorders by Flow Cytometry. Cytometry B Clin Cytom. 2010: 78:211-230.
2. Dezern AE, Borowitz MJ. ICCS/ESCCA consensus guidelines to detect GPI-deficient cells in paroxysmal nocturnal hemoglobinuria (PNH) and related disorders part 1 - clinical utility. Cytometry B Clin Cytom. 2018 Jan;94(1):16-22.

3. Liu H, Xia L, Weng J, et al. (2023). Efficacy and safety of the C5 inhibitor crovalimab in complement inhibitor-naive patients with PNH (COMMODORE 3): a multicenter, phase 3, single-arm study. American Journal of Hematology, 98(9), 1407-1414.
4. Parker CJ. Management of paroxysmal nocturnal hemoglobinuria in the era of complement inhibitory therapy. Hematology. 2011; 21-29
5. Parker CJ. Update on the diagnosis and management of paroxysmal nocturnal hemoglobinuria. Hematology Am Soc Hematol Educ Program. 2016;2016(1):208-216..
6. Piasky (crovalimab) [prescribing information]. South San Francisco, CA: Genentech Inc; June 2024.
7. Preis M, Lowrey CH. Laboratory tests for paroxysmal nocturnal hemoglobinuria (PNH). Am J Hematol. 2014;89(3):339-341.
8. Röth A, He G, Tong H, et al. Phase 3 randomized COMMODORE 2 trial: Crovalimab versus eculizumab in patients with paroxysmal nocturnal hemoglobinuria naive to complement inhibition. Am J Hematol. 2024 Sep;99(9):1768-1777.

Clinical Guideline Revision / History Information

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