



Nonprofit corporations and independent licensees  
of the Blue Cross and Blue Shield Association

Medical benefit drug policies are a source for BCBSM and BCN medical policy information only. These documents are not to be used to determine benefits or reimbursement. Please reference the appropriate certificate or contract for benefit information. This policy may be updated and therefore subject to change.

**Effective Date: 10/12/2023**

**Izervay™ (avacincaptad pegol)**

**HCPCS: J2782**

**Policy:**

*Requests must be supported by submission of chart notes and patient specific documentation.*

- A. Coverage of the requested drug is provided when all the following are met:
  - a. FDA approved indication
  - b. FDA approved age
  - c. Must not have geographic atrophy (GA) secondary to a condition other than dry AMD
  - d. Must have a visual acuity in the affected eye(s) of 20/320 or better
  - e. Must not be used in combination with Syfovre™ or any other medication for GA
  - f. Trial and failure, contraindication, OR intolerance to the preferred drugs as listed in BCBSM/BCN's utilization management medical drug list
  
- B. Quantity Limitations, Authorization Period and Renewal Criteria
  - a. Quantity Limits: Align with FDA recommended dosing
  - b. Authorization Period: One year at a time and align with FDA recommended duration of treatment
  - c. Renewal Criteria: Clinical documentation must be provided to confirm that current criteria are met and that the medication is providing clinical benefit

\*\*\*Note: Coverage and approval duration may differ for Medicare Part B members based on any applicable criteria outlined in Local Coverage Determinations (LCD) or National Coverage Determinations (NCD) as determined by Center for Medicare and Medicaid Services (CMS). See the CMS website at <http://www.cms.hhs.gov/>. Determination of coverage of Part B drugs is based on medically accepted indications which have supported citations included or approved for inclusion determined by CMS approved compendia.

**Background Information:**

- Geographic atrophy is an advanced and severe form of dry age-related macular degeneration (AMD). It is caused by the gradual breakdown of light-sensitive cells in the macula resulting in the growth of irreversible lesions in the retinal pigment epithelium (RPE). GA progression causes a gradual loss of visual function. Symptoms include scotomas, difficulty recognizing faces, decreased reading speed, impaired dark adaptation, low luminance deficit (LLD), impaired contrast sensitivity, and difficulty driving at night. More than half of all patients with GA will experience

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significant impairment of everyday vision, and about 20% of patients will develop severe vision loss with visual acuity of 20/200 or worse.

- The exact cause of GA is unknown but it is thought the disease is the result of a multifactorial process. The most significant risk factors include age and family history with genetics playing a role in disease development. It is thought errors found in the genes of the complement cascade may cause inflammation making the eye more susceptible to GA. Smoking and a higher body mass index are also risk factors.
- Diagnosis is made by an ophthalmologist during a dilated exam and/or with retinal imaging. In a dilated exam, geographic atrophy appears as a patch of retina that's missing its dark melanin pigment. Imaging techniques including retinal color photographs, optical coherence tomography (OCT), or autofluorescence photographs can also be used to detect GA.
- Izervay is a C5 complement inhibitor indicated for the treatment of GA secondary to AMD. It targets the complement overactivation generating GA progression preventing lesion growth and reducing the likelihood of severe disease.
- GA can be secondary to other conditions outside of AMD. Those include Stargardt disease, cone rod dystrophy, or toxic maculopathies like plaquenil maculopathy. Izervay has only been studied in patients with GA secondary to dry AMD and therefore should not be used to treat GA secondary to other conditions.
- Izervay has not been studied in patients with a visual acuity worse than 20/320. Use should be limited to those patients with visual acuity equal to or better than 20/320.

#### References:

1. Izervay [prescribing information]. Parsippany, NJ: Iveric bio, Inc.; August 2023.
2. Jaffe GJ, Westby K, Csaky KG, et al. C5 inhibitor avacincaptad pegol for geographic atrophy due to age-related macular degeneration: a randomized pivotal phase 2/3 trial. *Ophthalmology*. 2021 Apr; 128 (4): 576 - 86.
3. Patel SS, Lally DR, Hsu J, et al. Avacincaptad pegol for geographic atrophy secondary to age-related macular degeneration: 18-month findings from the GATHER1 trial. *Eye*. 2023 March 24. Available at: <https://doi.org/10.1038/s41433-023-02497-w>. Accessed on August 8, 2023.
4. Clinicaltrials.gov. A phase 3 multicenter, randomized, double masked, sham- controlled clinical trial to assess the safety and efficacy of intravitreal administration of Zimura (complement C5 inhibitor) in patients with geographic atrophy secondary to age-related macular degeneration (NCT 04435366). Available at: <https://clinicaltrials.gov/ct2/show/NCT04435366>. Accessed on August 8, 2023.
5. The Eye Diseases Prevalence Research Group. Prevalence of age-related macular degeneration in the United States. *Arch Ophthalmol*. 2004; 122 (4): 564 – 572.
6. Flaxel CJ, Adelman RA, Bailey ST, et al. Age-related macular degeneration preferred practice pattern. *Ophthalmology*. 2020 Jan (updated March 2022); 127 (1): 1 - 65.

Policy History												
#	Date	Change Description										
1.3	Effective Date: 10/15/2023	UM medical management system update for MAPPO and BCNA <table border="1"> <thead> <tr> <th>Line of Business</th> <th>PA Required in Medical Management System (Yes/No)</th> </tr> </thead> <tbody> <tr> <td>BCBS</td> <td>Yes</td> </tr> <tr> <td>BCN</td> <td>Yes</td> </tr> <tr> <td>MAPPO</td> <td>Yes</td> </tr> <tr> <td>BCNA</td> <td>Yes</td> </tr> </tbody> </table>	Line of Business	PA Required in Medical Management System (Yes/No)	BCBS	Yes	BCN	Yes	MAPPO	Yes	BCNA	Yes
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BCBS	Yes											
BCN	Yes											
MAPPO	Yes											
BCNA	Yes											
1.2	Effective Date: 10/12/2023	New policy - this criteria replaces previously approved preliminary criteria										
1.1	Effective Date: 08/17/2023	UM medical management system update for BCBSM and BCN <table border="1"> <thead> <tr> <th>Line of Business</th> <th>PA Required in Medical Management System (Yes/No)</th> </tr> </thead> <tbody> <tr> <td>BCBS</td> <td>Yes</td> </tr> <tr> <td>BCN</td> <td>Yes</td> </tr> <tr> <td>MAPPO</td> <td>No</td> </tr> <tr> <td>BCNA</td> <td>No</td> </tr> </tbody> </table>	Line of Business	PA Required in Medical Management System (Yes/No)	BCBS	Yes	BCN	Yes	MAPPO	No	BCNA	No
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1.0	Effective Date: 06/08/2023	Preliminary drug review <table border="1"> <thead> <tr> <th>Line of Business</th> <th>PA Required in Medical Management System (Yes/No)</th> </tr> </thead> <tbody> <tr> <td>BCBS</td> <td>No</td> </tr> <tr> <td>BCN</td> <td>No</td> </tr> <tr> <td>MAPPO</td> <td>No</td> </tr> <tr> <td>BCNA</td> <td>No</td> </tr> </tbody> </table>	Line of Business	PA Required in Medical Management System (Yes/No)	BCBS	No	BCN	No	MAPPO	No	BCNA	No
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\* The prescribing information for a drug is subject to change. To ensure you are reading the most current information it is advised that you reference the most updated prescribing information by visiting the drug or manufacturer website or <http://dailymed.nlm.nih.gov/dailymed/index.cfm>.

# Blue Cross Blue Shield/Blue Care Network of Michigan Medication Authorization Request Form



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This form is to be used by participating physicians to obtain coverage for **drugs covered under the medical benefit**. For commercial members only, please complete this form and submit via fax to 1-877-325-5979. If you have any questions regarding this process, please contact BCBSM Provider Relations and Servicing or the Medical Drug Helpdesk at 1-800-437-3803 for assistance.

PATIENT INFORMATION	PHYSICIAN INFORMATION
<b>Name</b>	<b>Name</b>
<b>ID Number</b>	<b>Specialty</b>
<b>D.O.B.</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Address</b>
<b>Diagnosis</b>	<b>City /State/Zip</b>
<b>Drug Name</b>	<b>Phone/Fax: P: (     )     -     F: (     )     -</b>
<b>Dose and Quantity</b>	<b>NPI</b>
<b>Directions</b>	<b>Contact Person</b>
<b>Date of Service(s)</b>	<b>Contact Person Phone / Ext.</b>

### STEP 1: DISEASE STATE INFORMATION

1. Is this request for:  Initiation       Continuation      *Date patient started therapy:* \_\_\_\_\_
2. Administered by patient or a medical professional?  patient (self)       health care professional (physician, nurse, etc.)
3. Site of administration?  Provider office/Home infusion       Other: \_\_\_\_\_  
 Hospital outpatient facility (go to #4)      *Reason for Hospital Outpatient administration:* \_\_\_\_\_  
 Hospital inpatient facility for Car-T therapy only (for example: Kymriah, Yescarta, or Tecartus) (go to #5)
4. Please specify location of administration if hospital outpatient infusion: \_\_\_\_\_
5. Please specify location of administration if hospital inpatient infusion: \_\_\_\_\_
6. Please provide the NPI number for the place of administration: \_\_\_\_\_
7. **Initiation AND Continuation of therapy:**
  - a. What is the patient's diagnosis? \_\_\_\_\_
  - b. What other medication has the patient received for their condition? Please list \_\_\_\_\_  
    - i. Please describe the response to previous therapies: \_\_\_\_\_
  - c. Will the patient be receiving any other treatment for the listed condition while on this medication? Please list: \_\_\_\_\_
  - d. Please list any labs values important for diagnosing or monitoring this patient's condition: \_\_\_\_\_
8. **Continuation of therapy:**
  - a. Has the patient progressed while on this medication?  yes     no
  - b. How has the patient's condition changed while on this medication?  
 Improved; Please describe: \_\_\_\_\_  
 Stable; please describe: \_\_\_\_\_  
 Worsened; Please describe: \_\_\_\_\_  
 Other; Please describe: \_\_\_\_\_

*Chart notes are required for the processing of all requests. Please add any other supporting medical information necessary for our review (required)*

**Coverage will not be provided if the prescribing physician's signature and date are not reflected on this document.**

Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

<b>Physician's Name</b>	<b>Physician Signature</b>	<b>Date</b>
<b>Step 2:</b> Checklist	<input type="checkbox"/> Form Completely Filled Out <input type="checkbox"/> Provide chart notes	<input type="checkbox"/> Attach test results
<b>Step 3:</b> Submit	<b>By Fax: BCBSM Specialty Pharmacy Mailbox 1-877-325-5979</b>	<b>By Mail: BCBSM Specialty Pharmacy Program P.O. Box 312320, Detroit, MI 48231-2320</b>

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