SAMPLE LETTER OF MEDICAL NECESSITY FOR ULTOMIRIS® (ravulizumab-cwvz) INJECTION

In Adult Patients Who Have Anti-Acetylcholine Receptor (Anti-AChR) Antibody-Positive Generalized Myasthenia Gravis (gMG)

Payers may request a letter of medical necessity to support coverage of ULTOMIRIS. The letter should explain why the drug is medically necessary for the specific patient and may include supporting documentation (eg, medical records, peer-reviewed literature, Prescribing Information, clinical treatment history, etc). The letter may be submitted as part of a prior authorization (PA) request, with the claim form, or in response to a payer's request for additional documentation. The letter should include patient-specific information, be on your letterhead, be signed by the prescriber, and be submitted to a payer to support a PA request or claim for ULTOMIRIS.

This sample letter of medical necessity is provided for informational purposes only and is not based on legal advice or official guidance from payers. It is not intended to increase or maximize reimbursement by any payer. Alexion does not warrant, promise, guarantee, or make any statement that the use of this information will result in coverage or payment for ULTOMIRIS or that any payment received will cover providers' costs.

INDICATION

ULTOMIRIS is indicated for the treatment of adult patients with generalized myasthenia gravis (gMG) who are anti-acetylcholine receptor (AChR) antibody-positive.

SELECT IMPORTANT SAFETY INFORMATION

WARNING: SERIOUS MENINGOCOCCAL INFECTIONS

Life-threatening meningococcal infections/sepsis have occurred in patients treated with ULTOMIRIS. Meningococcal infection may become rapidly life-threatening or fatal if not recognized and treated early.

- **Comply with the most current Advisory Committee on Immunization Practices (ACIP) recommendations for meningococcal vaccination in patients with complement deficiencies.**
- **Immunize patients with meningococcal vaccines at least 2 weeks prior to administering the first dose of ULTOMIRIS, unless the risks of delaying ULTOMIRIS therapy outweigh the risk of developing a meningococcal infection. See *Warnings and Precautions* for additional guidance on the management of the risk of meningococcal infection.**
- **Vaccination reduces, but does not eliminate, the risk of meningococcal infections. Monitor patients for early signs of meningococcal infections and evaluate immediately if infection is suspected.**

Because of the risk of serious meningococcal infections, ULTOMIRIS is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called ULTOMIRIS REMS.

Please see Important Safety Information on pages 5, 6, and 7 and the full Prescribing Information for ULTOMIRIS® (ravulizumab-cwvz), including Boxed WARNING regarding serious and life-threatening meningococcal infections/sepsis.

US/ULT-g/0060 09/22

ULTOMIRIS®
(ravulizumab-cwvz)
injection for intravenous use
300 mg/3 mL vial

[John Doe, MD]
[Address]
[City, State ZIP Code]
[(888) 555-5555]

SAMPLE ONLY
PLEASE COPY ONTO YOUR LETTERHEAD.

[Date]
[Contact Name], [Title], [Name of Health Insurance Plan or PBM]
[Address]
[City, State ZIP Code]

Letter of Medical Necessity for ULTOMIRIS® (ravulizumab-cwvz)
[Request for Expedited Review Due to Medical Urgency]
Insured: [Name]; Policy Number: [Number]; Group Number: [Number]
Date(s) of service: [Date(s)]

Dear [Contact Name],

I am writing on behalf of my patient, [First Name] [Last Name], to request that [name of health insurance company] approve coverage and appropriate reimbursement associated with [Mr/Ms/Mrs/other title] [Last Name]'s treatment with ULTOMIRIS. ULTOMIRIS is indicated for the treatment of adult patients with generalized myasthenia gravis (gMG) who are anti-acetylcholine receptor (anti-AChR) antibody-positive.

Patient Medical Overview

[Name of patient] is a[n] [age]-year-old [gender] born [MM-DD-YYYY] who requires treatment with ULTOMIRIS after being diagnosed with anti-AChR antibody-positive gMG on [date of diagnosis MM-DD-YYYY].

Medical History (including Clinical Signs, Symptoms, and Laboratory Results) [see page 3 for reference]

[Provide relevant gMG clinical signs and symptoms and describe the severity of disease of your patient's current presentation and disease progression (eg, patient's medical history of myasthenic crises) based on your medical opinion. Include specific clinical presentations, relevant patient-specific clinical scenarios demonstrating serious medical need, and previous treatments for gMG.]

For C5 Inhibitor–Treated Patients Transitioning to ULTOMIRIS (if relevant) [see page 4 for reference]

[Provide treatment rationale for transitioning your patient from an existing C5 therapy to ULTOMIRIS.]

In my medical opinion, ULTOMIRIS is the most appropriate treatment for [name of patient]'s anti-AChR antibody-positive gMG based on the clinical efficacy and safety data.

Treatment Plan

For adult patients with anti-AChR antibody-positive gMG, the recommended dosing regimen with ULTOMIRIS includes a weight-based loading dose. Maintenance dosing starts 2 weeks after the initial loading dose and then occurs once every 8 weeks.

Patients 40 to <60 kg: 2,400 mg loading dose; 3,000 mg maintenance dose (every 8 weeks)
Patients 60 to <100 kg: 2,700 mg loading dose; 3,300 mg maintenance dose (every 8 weeks)
Patients ≥100 kg: 3,000 mg loading dose; 3,600 mg maintenance dose (every 8 weeks)

Summary

Based on the above facts, I am confident you will agree that ULTOMIRIS, a complement inhibitor, is indicated and medically necessary for this patient. For your convenience, I am enclosing [list enclosures such as supporting clinical documentation, Prescribing Information, FDA approval letter for ULTOMIRIS in gMG, etc.].

If you have any further questions, please feel free to call me at [physician's telephone number] to discuss. Thank you in advance for your immediate attention to this request.

Sincerely,

[Physician's Name], MD
[Physician's Identification Number]
[Physician's Practice Name]
[Physician's Phone Number]
[Physician's Fax Number]
[Physician's Email]

Enclosures
[Supporting clinical documentation, Prescribing Information, FDA press release for ULTOMIRIS in gMG, etc.]

MEDICAL HISTORY (INCLUDING CLINICAL SIGNS, SYMPTOMS, AND LABORATORY RESULTS)

- ☐ Evidence of a positive serological test for **anti-AChR antibodies** (include laboratory results and date) and any other context you consider relevant to the laboratory result
- ☐ Status based on the **Myasthenia Gravis Foundation of America (MGFA) Clinical Classification** Class I to V (MGFA Class II-IV assessed in CHAMPION-MG clinical trial population)[1]
- ☐ Score on the **Myasthenia Gravis-Activities of Daily Living (MG-ADL)** scale 0–24; MG-ADL score of ≥6 assessed in CHAMPION-MG clinical trial population,[1] including case notes and other clinical impressions. If patient or caregiver has tracked changes in their MG-ADL score, include the score history; payers may require the MG-ADL scores for initial approval and reauthorizations of treatment
- ☐ Previous experience, if any, with receiving ULTOMIRIS, including any changes in the **Quantitative Myasthenia Gravis (QMG)** total score (scale 0–39)
- ☐ **Previous treatment** on corticosteroids, immunosuppressants, intravenous immunoglobulin, chronic plasmapheresis, plasma exchange, eculizumab, and/or efgartigimod [such as name of treatments, dosage, frequency, duration including dates, and impact, if any, on patient's symptoms]
- ☐ **Contraindications,** if any, to any agents used in treatment of gMG
- ☐ **History of complications, exacerbations, or myasthenic crises** leading to emergency room visits, hospital admissions, and/or intensive care unit stays
- ☐ Record of receiving the **meningococcal vaccines** at least 2 weeks prior to the first proposed treatment with ULTOMIRIS
- ☐ **Clinical signs and symptoms** to help describe the patient's current clinical presentation[2,]*:
  - ○ Ocular muscle weakness: Ptosis and diplopia, or sometimes blurry vision
  - ○ Axial muscle weakness: Neck flexor or extensor weakness
  - ○ Oropharyngeal muscle weakness: Chewing difficulties, dysarthria, dysphagia, facial muscles frequently involving eyelid closure, drooling
  - ○ Limb muscle weakness: Proximal limb weakness with arms more affected than legs
  - ○ Respiratory muscle weakness: Orthopnea, tachypnea, exertional dyspnea-poor inspiratory sniff, cough

*List is not all inclusive of gMG clinical signs and symptoms.

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TREATMENT RATIONALE FOR TRANSITIONING C5 INHIBITOR–TREATED PATIENTS TO ULTOMIRIS

- The patient had a previous diagnosis of gMG that met requirements for initiating eculizumab, was clinically stable on eculizumab, and has had a beneficial response as evidenced by [change from baseline in MG-ADL score, change from baseline in QMG total score][1]
- Switching to ULTOMIRIS reduces maintenance dosing frequency to 6 to 7 infusions per year, from 26 infusions per year with eculizumab[1]
- ULTOMIRIS has a half-life that is ~4x longer than that of eculizumab[1]
- The patient will not receive ULTOMIRIS concomitantly with other complement inhibitors (eg, eculizumab) or Fc receptor blockers (eg, efgartigimod)

Explore Alexion Access Navigator

ALEXION ACCESS NAVIGATOR

Alexion Access Navigator is a dedicated resource website for US Healthcare Professionals and their offices that contains downloadable access and reimbursement materials for ULTOMIRIS® (ravulizumab-cwvz).

Online: https://alexionaccessnavigator.com

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INDICATION AND IMPORTANT SAFETY INFORMATION

INDICATION

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IMPORTANT SAFETY INFORMATION

WARNING: SERIOUS MENINGOCOCCAL INFECTIONS

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- **Comply with the most current Advisory Committee on Immunization Practices (ACIP) recommendations for meningococcal vaccination in patients with complement deficiencies.**
- **Immunize patients with meningococcal vaccines at least 2 weeks prior to administering the first dose of ULTOMIRIS, unless the risks of delaying ULTOMIRIS therapy outweigh the risk of developing a meningococcal infection. See *Warnings and Precautions* for additional guidance on the management of the risk of meningococcal infection.**
- **Vaccination reduces, but does not eliminate, the risk of meningococcal infections. Monitor patients for early signs of meningococcal infections and evaluate immediately if infection is suspected.**

Because of the risk of serious meningococcal infections, ULTOMIRIS is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called ULTOMIRIS REMS.

CONTRAINDICATIONS

- Patients with unresolved *Neisseria meningitidis* infection.
- Patients who are not currently vaccinated against *Neisseria meningitidis*, unless the risks of delaying ULTOMIRIS treatment outweigh the risks of developing a meningococcal infection.

WARNINGS AND PRECAUTIONS

Serious Meningococcal Infections

Life-threatening meningococcal infections have occurred in patients treated with ULTOMIRIS. The use of ULTOMIRIS increases a patient's susceptibility to serious meningococcal infections (septicemia and/or meningitis). Meningococcal disease due to any serogroup may occur.

Vaccinate or revaccinate for meningococcal disease according to the most current ACIP recommendations for patients with complement deficiencies. Immunize patients without history of meningococcal vaccination at least 2 weeks prior to the first dose of ULTOMIRIS. Patients who initiate ULTOMIRIS treatment less than 2 weeks after receiving meningococcal vaccine(s) must receive appropriate prophylactic antibiotics until 2 weeks after vaccination.

In clinical studies, 2 adult patients with gMG were treated with ULTOMIRIS less than 2 weeks after meningococcal vaccination. All of these patients received antibiotics for prophylaxis of meningococcal infection until at least 2 weeks after meningococcal vaccination. The benefits and risks of antibiotic prophylaxis for prevention of meningococcal infections in patients receiving ULTOMIRIS have not been established. Consider discontinuation of ULTOMIRIS in patients who are undergoing treatment for serious meningococcal infection.

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IMPORTANT SAFETY INFORMATION (CONTINUED)

WARNINGS AND PRECAUTIONS (CONTINUED)

ULTOMIRIS REMS

Due to the risk of meningococcal infections, ULTOMIRIS is available only through a restricted program under a REMS called ULTOMIRIS REMS.

Under the ULTOMIRIS REMS, prescribers must enroll in the program. Prescribers must counsel patients about the risk of meningococcal infection/sepsis, provide the patients with the REMS educational materials, and ensure patients are vaccinated with meningococcal vaccines.

Additional information on the REMS requirements is available at www.ultomirisrems.com or 1-888-765-4747.

Other Infections

Patients may have increased susceptibility to infections, especially with encapsulated bacteria, such as infections caused by *Neisseria meningitidis* but also *Streptococcus pneumoniae*, *Haemophilus influenzae*, and to a lesser extent, *Neisseria gonorrhoeae*. If ULTOMIRIS is administered to patients with active systemic infections, monitor closely for worsening infection.

Thromboembolic Event Management

The effect of withdrawal of anticoagulant therapy during treatment with ULTOMIRIS has not been established. Treatment should not alter anticoagulant management.

Infusion-Related Reactions

Intravenous administration of ULTOMIRIS may result in systemic infusion-related reactions, including anaphylaxis and hypersensitivity reactions. In clinical trials, infusion-related reactions occurred in approximately 1% of patients treated with ULTOMIRIS. These events included lower back pain, drop in blood pressure, elevation in blood pressure, limb discomfort, drug hypersensitivity (allergic reaction), dysgeusia (bad taste), and drowsiness. These reactions did not require discontinuation of ULTOMIRIS. If signs of cardiovascular instability or respiratory compromise occur, interrupt ULTOMIRIS infusion and institute appropriate supportive measures.

ADVERSE REACTIONS

Most common adverse reactions in adult patients with gMG (incidence ≥10%) were diarrhea and upper respiratory tract infection. Serious adverse reactions were reported in 20 (23%) of patients treated with ULTOMIRIS and in 14 (16%) patients receiving placebo. The most frequent serious adverse reactions were infections reported in at least 8 (9%) patients treated with ULTOMIRIS and in 4 (4%) patients treated with placebo. Of these infections, one fatal case of COVID-19 pneumonia was identified in a patient treated with ULTOMIRIS and one case of infection led to discontinuation of ULTOMIRIS.

IMPORTANT SAFETY INFORMATION (CONTINUED)

DRUG INTERACTIONS

Plasma Exchange, Plasmapheresis, and Intravenous Immunoglobulins

Concomitant use of ULTOMIRIS with plasma exchange (PE), plasmapheresis (PP), or intravenous immunoglobulin (IVIg) treatment can reduce serum ravulizumab concentrations and requires a supplemental dose of ULTOMIRIS.

Neonatal Fc Receptor Blockers

Concomitant use of ULTOMIRIS with neonatal Fc receptor (FcRn) blockers (e.g., efgartigimod) may lower systemic exposures and reduce effectiveness of ULTOMIRIS. Closely monitor for reduced effectiveness of ULTOMIRIS.

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References: 1. ULTOMIRIS. Prescribing information. Alexion Pharmaceuticals, Inc. **2.** Meriggioli MN, Sanders DB. *Lancet Neurol*. 2009;8(5):475-490.

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