| Reference number(s) |
| --- |
| 7346-A |

# Specialty Guideline Management
# Yartemlea

## Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

| Brand Name | Generic Name |
| --- | --- |
| Yartemlea | narsoplimab-wuug |

## Indications

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

### FDA-Approved Indication[1]

Yartemlea is indicated for the treatment of adult and pediatric patients 2 years of age and older with hematopoietic stem cell transplant-associated thrombotic microangiopathy (TA-TMA).

All other indications are considered experimental/investigational and not medically necessary.

## Documentation

Submission of the following information is necessary to initiate the prior authorization review:

- For initial requests:
    - Chart notes or medical record documentation confirming the diagnosis of TA-TMA
    - Laboratory report confirming ADAMTS13 activity

- For continuation requests: Chart notes or medical record documentation supporting positive clinical response to therapy

# Coverage Criteria

## Transplant-Associated Thrombotic Microangiopathy (TA-TMA)[1]

Authorization of 6 months may be granted for the treatment of hematopoietic stem cell transplant-associated thrombotic microangiopathy (TA-TMA) when all of the following criteria are met:

- The member is 2 years of age or older
- Diagnosis has been confirmed by all of the following:
    - Platelet count < 150,000/μL
    - Evidence of microangiopathic hemolysis (presence of schistocytes, serum LDH greater than the upper limit of normal [ULN] and/or haptoglobin less than the lower limit of normal [LLN])
- The member has an ADAMTS13 activity level ≥10%
- The requested medication will not be used in combination with another complement inhibitor (e.g., Soliris, Ultomiris) or Defitelio (defibrotide)

# Continuation of Therapy

Authorization of 12 months (including new members) may be granted for continued treatment in members requesting reauthorization for an indication listed in the coverage criteria section when there is no unacceptable toxicity while on the current regimen, the member demonstrates a positive response to therapy (e.g., improvement in platelet levels, normalization of lactate dehydrogenase [LDH] and haptoglobin levels), and the requested medication will not be used in combination with another complement inhibitor (e.g., Soliris, Ultomiris) or Defitelio (defibrotide).

# References

1. Yartemlea [package insert]. Seattle, WA: Omeros Corporation; December 2025.