

Specialty Guideline Management

Piasky

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
Piasky	crovalimab-akkz

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 Indications¹

Piasky is 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.

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: Flow cytometry used to show results of glycosylphosphatidylinositol-anchored proteins (GPI-APs) deficiency.
- For continuation requests: Chart notes or medical record documentation supporting positive clinical response.

Coverage Criteria

Paroxysmal Nocturnal Hemoglobinuria (PNH)¹⁻⁶

Authorization of 6 months may be granted for treatment of paroxysmal nocturnal hemoglobinuria (PNH) when all of the following criteria are met:

- Member is 13 years of age or older.
- Member has a body weight of at least 40 kg.
- The diagnosis of PNH was confirmed by detecting a deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs) (e.g., at least 5% PNH cells, at least 51% of GPI-AP deficient polymorphonuclear cells).
- Flow cytometry is used to demonstrate GPI-APs deficiency.
- Member has and exhibits clinical manifestations of disease (e.g., lactate dehydrogenase [LDH] > 1.5 upper limit of normal [ULN], thrombosis, renal dysfunction, pulmonary hypertension, dysphagia)
- The requested medication will not be used in combination with another complement inhibitor (e.g., Empaveli, Fabhalta, Soliris, Ultomiris) for the treatment of PNH.

Continuation of Therapy

Paroxysmal Nocturnal Hemoglobinuria (PNH)

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization when all of the following criteria are met:

- There is no evidence of unacceptable toxicity or disease progression while on the current regimen.
- The member demonstrates a positive response to therapy (e.g., improvement in hemoglobin levels, normalization of lactate dehydrogenase [LDH] levels).
- The requested medication will not be used in combination with another complement inhibitor (e.g., Empaveli, Fabhalta Soliris, Ultomiris) for the treatment of PNH.

References

1. Piasky [package insert]. South San Francisco, CA: Genentech, Inc.; June 2024.
2. Parker CJ. Management of paroxysmal nocturnal hemoglobinuria in the era of complement inhibitory therapy. Hematology. 2011; 21-29.

Reference number(s)
6538-A

3. 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.
4. Preis M, Lowrey CH. Laboratory tests for paroxysmal nocturnal hemoglobinuria (PNH). Am J Hematol. 2014;89(3):339-341.
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. 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.