

Clinical Policy: Plasminogen, human-tvmh (Ryplazim)

Reference Number: CP.PHAR.513

Effective Date: 06.04.21

Last Review Date: 02.22

Line of Business: Commercial, HIM, Medicaid

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Plasminogen (Ryplazim[®]) is a plasma-derived human plasminogen.

FDA Approved Indication(s)

Ryplazim is indicated for the treatment of patients with plasminogen deficiency type 1 (hypoplasminogenemia).

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that Ryplazim is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Plasminogen Deficiency Type 1 (must meet all):

1. Diagnosis of symptomatic congenital plasminogen deficiency (C-PLGD) as evidenced by documentation of two of the following (a - c):
 - a. Presence of a *PLG* mutation;
 - b. Plasminogen activity level \leq 45%;
 - c. Signs or symptoms consistent with C-PLGD (*see Appendix D*);
2. Prescribed by or in consultation with a hematologist;
3. Age \geq 11 months;
4. Dose does not exceed 6.6 mg/kg every second, third, or fourth day (*based upon individual pharmacokinetics*).

Approval duration: 6 months

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Plasminogen Deficiency Type 1 (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;

2. Member is responding positively to therapy as evidenced by, including but not limited to, improvement in C-PLGD-associated signs or symptoms (e.g., improvement in the size of visible lesions, imaging of nonvisible lesions, or spirometry if pulmonary involvement (*see Appendix D*));
3. If request is for a dose increase, new dose does not exceed 6.6 mg/kg every second, third, or fourth day (*based upon individual pharmacokinetics*).

Approval duration: 12 months

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A.** Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

C-PLGD: congenital plasminogen deficiency

FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): known hypersensitivity to plasminogen, or other components of Ryplazim
- Boxed warning(s): none reported

Appendix D: Clinical Signs and Symptoms of Congenital Plasminogen Deficiency

C-PLGD (also known as type 1 plasminogen deficiency or hypoplasminoginemia) is a rare autosomal-recessive disorder of the fibrinolytic system. The primary manifestation is development of abnormal extravascular accumulation or growth of fibrin-rich, woody (ligneous) pseudomembranous lesions on mucous membranes throughout the body. Wound healing also may be impaired. The disease appears to be most severe in infants and children. Examples of lesion locations and associated complications (not all inclusive):

- Conjunctival lesions “ligneous conjunctivitis” - most common lesion (may result in visual impairment or blindness)
- Tracheobronchial or renal lesions (may result in respiratory or renal failure)
- Lesions in the cerebral ventricular system (may result in congenital occlusive hydrocephalus)

- Lesions in the ears, nasopharynx, and oral cavity (may result in hearing loss, liginous tonsillitis or liginous gingivitis with tooth loss)
- Lesions in the genitourinary tract (may result in dysmenorrhea, abnormal menses, dyspareunia or infertility)

Shapiro, Amy D. et al. An international registry of patients with plasminogen deficiency (HISTORY). *Haematologica*. 2020 Mar; 105(3):554-561.

Appendix E: Ryplazim Pivotal Trial

- In a pivotal phase 2/3 clinical trial for the treatment of C-PLGD, 15 patients with C-PLGD were enrolled, including six pediatric patients, for 48 weeks of therapy with Ryplazim.
- All patients treated with Ryplazim achieved the targeted increase from baseline in their individual trough plasminogen activity levels through 12 weeks of therapy.
- In addition, all patients who had active visible lesions when enrolled in the trial had complete healing of their measurable lesions within 48 weeks of initiating therapy.
- Adverse events reported in the clinical study were characterized as mild, with no patient deaths, serious adverse events or adverse events that caused study discontinuation.

1. Shapiro, Amy D. et al. Plasminogen replacement therapy for the treatment of children and adults with congenital plasminogen deficiency. *Blood*. 2018 Mar 22; 131(12):1301-1310.
2. A study of Prometic plasminogen IV infusion in subjects with hypoplasminogenemia. Trial record 2 of 2 for: 2002C011G. *ClinicalTrials.gov* Identifier: NCT02690714. Available at: <https://clinicaltrials.gov/ct2/show/NCT02690714?term=2002C011G&draw=2&rank=2>. Accessed October 1, 2020.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
C-PLGD	6.6 mg/kg body weight given every 2 to 4 days (<i>based upon individual pharmacokinetics</i>)	6.6 mg/kg

VI. Product Availability

Single-dose vial: 68.8 mg in 50 ml vial (5.5 mg/ml of plasminogen after reconstitution)

VII. References

1. Ryplazim Prescribing Information. Prometic Bioproducts Inc: Laval, Quebec, Canada; June 2021. Available at: <https://www.fda.gov/media/149806/download>. Accessed July 6, 2021.
2. Product Pipeline: Plasminogen Deficiency. Liminal BioSciences, Inc. Available at: <https://liminalbiosciences.com/pipeline/plasminogen/plasminogen-deficiency-clinical-trials/>. Accessed October 1, 2020.
3. Shapiro, Amy D. et al. An international registry of patients with plasminogen deficiency (HISTORY). *Haematologica*. 2020 Mar; 105(3):554-561.
4. Shapiro, Amy D. et al. Plasminogen replacement therapy for the treatment of children and adults with congenital plasminogen deficiency. *Blood*. 2018 Mar 22; 131(12):1301-1310.
5. Mehta R, Shapiro AD. Plasminogen deficiency. *Haemophilia*. 2008; 14, 1261–1268. DOI: 10.1111/j.1365-2516.2008.01825.x.

6. Schuster V, Hugle B, Tefs K. Plasminogen deficiency. *J Thromb Haemost* 2007; 5:2315–22.
7. Tefs K, Gueorguieva M, Klammt J, et al. Molecular and clinical spectrum of type I plasminogen deficiency: a series of 50 patients. *Blood*, 1 November 2006; 108(9):3021-3026.
8. A treatment protocol for expanded access administration of Prometic plasminogen due to closure of clinical trial. Trial record 1 of 2 for: 2002C011G. ClinicalTrials.gov Identifier: NCT03642691. Available at: <https://clinicaltrials.gov/ct2/show/NCT03642691?term=2002C011G&draw=2&rank=1>. Accessed October 1, 2020.
9. A study of Prometic plasminogen IV infusion in subjects with hypoplasminogenemia. Trial record 2 of 2 for: 2002C011G. ClinicalTrials.gov Identifier: NCT02690714. Available at: <https://clinicaltrials.gov/ct2/show/NCT02690714?term=2002C011G&draw=2&rank=2>. Accessed October 1, 2020.
10. Type 1 plasminogen deficiency. Genetic and Rare Diseases Information Center. National Institutes of Health. Available at <https://rarediseases.info.nih.gov/diseases/4380/type-1-plasminogen-deficiency>. Accessed October 6, 2020.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J2998	Injection, plasminogen, human-tvmh, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created pre-emptively	10.01.20	11.20
4Q 2021 annual review: RT4: drug is now FDA-approved; criteria updated per FDA labeling; modified continuation of therapy to require increased trough plasminogen activity; modified examples of positive response to remove qualification of one year on treatment; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	07.06.21	11.21
Per prescribing information, modified minimum age from at least 2 years or older to 11 months or older; modified diagnostic requirements from all (a, b, and c) to two of three; removed requirement for increased trough plasminogen activity on continued therapy; HCPCS code updated.	01.10.22	02.22
Added HCPCS code [J2998].	06.30.22	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted

standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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