Clinical Policy: Narsoplimab-wuug (Yartemlea)

Reference Number: CP.PHAR.527
Effective Date: 12.24.25
Last Review Date: 05.26
Line of Business: Commercial, HIM/ICHRA, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Narsoplimab-wuug (Yartemlea™) is a mannan-binding lectin-associated serine protease-2 (MASP-2) inhibitor.

FDA Approved Indication(s)

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).

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 Yartemlea is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Hematopoietic Stem Cell Transplant-Associated Thrombotic Microangiopathy (must meet all)**:**

1. Diagnosis of hematopoietic stem cell TA-TMA;
2. Prescribed by or in consultation with a hematologist or transplant specialist;
3. Age ≥ 2 years;
4. Member has signs of persistent TMA as evidenced by presence of all of the following for at least 2 weeks after modification or discontinuation of calcineurin inhibitor therapy (e.g., cyclosporine, tacrolimus) (a, b, and c):
   a. Platelet count < 150 x 10^9/L;
   b. Evidence of hemolysis (e.g., serum lactate dehydrogenase [LDH] above the upper limit of normal, presence of schistocytes);
   c. Serum creatinine ≥ 2 times pre-transplantation baseline or member requires dialysis;
5. Documentation that member does not have any of the following (a, b, and c):
   a. A disintegrin and metalloproteinase with thrombospondin type 1 motif, member 13 (ADAMTS13) deficiency;
   b. Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS);
   c. Atypical hemolytic uremic syndrome (aHUS);
6. Yartemlea is not prescribed concurrently with Soliris®/Bkemv™/Epysqli® or Ultomiris®;
7. Member has not received Yartemlea for > 16 weeks;

8. Dose does not exceed one of the following (a or b):
   a. Weight ≥ 50 kg: 370 mg once weekly;
   b. Weight < 50 kg: 4 mg/kg once weekly.

Approval duration: 8 weeks

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Hematopoietic Stem Cell Transplant-Associated Thrombotic Microangiopathy (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy as evidenced by, including but not limited to, improvement in <u>any</u> of the following parameters (a, b, c, or d):
   a. Improved measures of hemolysis (e.g., normalization of LDH, decrease or absence of schistocytes);
   b. Increased or stabilized platelet counts;
   c. Improved or stabilized serum creatinine or estimated glomerular filtration rate (eGFR);
   d. Reduced need for dialysis;
3. Member has not received Yartemlea for > 16 weeks;
4. Yartemlea is not prescribed concurrently with Soliris/Bkemv/Epysqli or Ultomiris;
5. If request is for a dose increase, new dose does not exceed one of the following (a or b):
   a. Weight ≥ 50 kg: 370 mg twice weekly;
   b. Weight < 50 kg: 4 mg/kg twice weekly.

Approval duration: Up to 16 weeks total

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, 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/ICHRA, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
LDH: lactate dehydrogenase
MASP-2: mannan-binding lectin-associated serine protease-2
TA-TMA: transplant-associated thrombotic microangiopathy

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
TA-TMA	Administer as an IV infusion once weekly with weight-based dosing: • ≥ 50 kg: 370 mg IV once weekly • < 50 kg: 4 mg/kg IV once weekly	See regimen

Indication	Dosing Regimen	Maximum Dose
	Increase frequency to twice weekly if there is inadequate improvement in TA-TMA signs and symptoms.	

VI. Product Availability

Solution for injection in single-dose vial: 370 mg/2 mL

VII. References

1. Yartemlea Prescribing Information. Seattle, WA: Omeros; December 2025. Available at: https://pi.omeros.com/us/yartemlea-uspi.pdf. Accessed February 22, 2026.
2. Khaled SK, Claes K, Goh YT, et al. Narsoplimab, a mannan-binding lectin-associated serine protease-2 inhibitor, for the treatment of adult hematopoietic stem-cell transplantation-associated thrombotic microangiopathy. J Clin Oncol. 2022;40(22):2447-2457.
3. Schoettler ML, Carreras E, Cho B, et al. Harmonizing definitions for diagnostic criteria and prognostic assessment of transplantation-associated thrombotic microangiopathy: A report on behalf of the European Society for Blood and Marrow Transplantation, American Society for Transplantation and Cellular Therapy, Asia-Pacific Blood and Marrow Transplantation Group, and Center for International Blood and Marrow Transplant Research. Transplant Cell Ther. 2023;29(3):151-163.
4. Schoettler ML, Gavriilaki E, Carreras E, et al. An ASTCT, CIBMTR, EBMT, and APBMT consensus statement defining response criteria for hematopoietic cell transplantation associated thrombotic microangiopathy (TA-TMA) directed therapy. Transplant Cell Ther. 2025;31(9):610-623.

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
J1289	Injection, narsoplimab-wuug, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2022 annual review: no significant changes as drug is not yet FDA-approved; references reviewed and updated.	02.13.22	05.22
Template changes applied to other diagnoses/indications and continued therapy section.	10.04.22	
2Q 2023 annual review: no significant changes as drug is not yet FDA-approved; references reviewed and updated.	02.14.23	05.23
2Q 2024 annual review: no significant changes as the drug is not yet FDA-approved; references reviewed and updated.	01.11.24	05.24
2Q 2025 annual review: no significant changes as the drug is not yet FDA-approved; references reviewed and updated.	01.29.25	05.25

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Drug is now FDA approved – criteria updated per FDA labeling: for diagnostic criteria, clarified that LDH should be above the upper limit of normal, added presence of schistocytes as hemolysis example, clarified platelet count should be < 150 x 10^9/L, and clarified serum creatinine to be ≥ 2 times pre-transplantation baseline per published pivotal trial; added Bkemv/Epysqli biosimilars to Soliris concurrent prescribing exclusion; for continued criteria, added hemolysis example of decrease or absence of schistocytes and revised maximum duration of Yartemlea administration from 12 weeks to 16 weeks per pivotal trial experience; references reviewed and updated.	01.12.26	
2Q 2026 annual review: no significant changes; in initial therapy, added criterion that maximum duration of therapy doesn't exceed 16 weeks for review of new members already started on Yartemlea therapy; added HCPCS code references reviewed and updated. Added ICHRA line of business.	04.10.26	05.26
Added HCPCS code J1289 and removed codes C9399 and J3590.	06.02.26	

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.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or

regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.