JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Pharmacy Public** **Medical Management Drug Policies**	*Policy Number*	MMDP113
		Effective Date	07/17/2024
		Approval Date	07/17/2024
	Subject **Ryplazim**	*Supersedes Date*	N/A
		Page	1 of 2

This document applies to the following Participating Organizations:

US Family Health Plan

Keywords: Ryplazim

Table of Contents		Page Number
I.	POLICY	1
II.	POLICY CRITERIA	1
III.	AUTHORIZATION PERIOD/LIMITATIONS	1
IV.	EXCLUSIONS	1
V.	RECOMMENDED DOSE	1
VI.	CODES	2
VII.	REFERENCES	2
VIII.	APPROVALS	2

I. POLICY

A. Ryplazim (plasminogen, human-tvmh) will require prior authorization for medical benefit coverage to ensure appropriate use. The process for initiating a prior authorization request can be found in policy PHARM 20.

II. POLICY CRITERIA

A. Ryplazim may be approved for patients who meet the following:
   1. Documentation has been submitted showing the following:
      a. Diagnosis of Plasminogen deficiency type 1 (hypoplasminogenemia)
      b. Patient has a baseline plasminogen activity level of 45% or less
      c. Patient has a documented history of lesions and symptoms consistent with plasminogen deficiency type 1, such as ligneous conjunctivitis, ligneous gingivitis or gingival overgrowth, vision abnormalities, respiratory distress and/or obstruction, abnormal wound healing

III. AUTHORIZATION PERIOD/LIMITATIONS

A. Initial approval will be limited to 12 months of therapy
B. Continuation of therapy may be approved in 12-month intervals with documentation showing the patient has had a beneficial response to therapy, evidenced by at least one of the following signs of disease stability or disease improvement:
   1. improvement in lesion number and/or size, absence of new lesion development
   2. improvement in respiratory function
   3. increased quality of life

IV. EXCLUSIONS

A. Ryplazim will not be covered for the following:
   1. Any indications or uses that are not FDA-approved, or guideline-supported

V. RECOMMENDED DOSE

Please refer to the FDA-approved prescribing information, or clinical guidelines, for indication-specific dosing details.

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		Page	2 of 2

VI. CODES

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Note: The following CPT/HCPCS codes are included below for informational purposes. Inclusion or exclusion of a CPT/HCPCS code(s) below does not signify or imply member coverage or provider reimbursement. The member's specific benefit plan determines coverage.

Medication	HCPCS/CPT Code
Injection, plasminogen, human-tvmh, 1 mg	J2998

VII. REFERENCES

1. Ryplazim [prescribing information]. Fort Lee, NJ: Prometic Biotherapeutics Inc.; June 2023.
2. Shapiro AD, Nakar C, Parker JM, et al. Plasminogen replacement therapy for the treatment of children and adults with congenital plasminogen deficiency. Blood. 2018;131(12):1301-1310.
3. Celkan T. Plasminogen deficiency. J Thromb Thrombolysis. January 2017; 43(1):132-138.

VIII. APPROVALS

Signature on file at JHHC

DATE OF REVISION	SUMMARY OF CHANGE
07/17/2024	Policy creation

Review Date: 07/17/2024

Revision Date: