BlueCross BlueShield
Federal Employee Program
Blue Cross Blue Shield Association
750 9th St NW, Suite 900
Washington, D.C. 20001
1-800-624-5060
Fax 1-877-378-4727

5.90.065

Section:	Prescription Drugs	**Effective Date:**	April 1, 2025
Subsection:	Topical Products	**Original Policy Date:**	September 1, 2023
Subject:	Izervay	**Page:**	1 of 3

Last Review Date: March 7, 2025

Izervay

Description

Izervay (avacincaptad pegol)

Background
Izervay (avacincaptad pegol) is an RNA aptamer, a PEGylated oligonucleotide that binds to and inhibits complement protein C5. By inhibiting C5, Izervay may prevent its cleavage to C5a and C5b thus decreasing membrane attack complex (MAC) formation (1).

Regulatory Status
FDA-approved indication: Izervay is a complement inhibitor indicated for the treatment of geographic atrophy (GA) secondary to age-related macular degeneration (AMD) (1).

Izervay is contraindicated in ocular or periocular infections and in active intraocular inflammation (1).

Izervay carries warnings of endophthalmitis and retinal detachments, neovascular AMD, and increased intraocular pressure (IOP) (1).

The safety and effectiveness of Izervay in pediatric patients have not been established (1).

Related policies
Bevacizumab, Lucentis, Susvimo, VEGF Inhibitors

Policy

This policy statement applies to clinical review performed for pre-service (Prior Approval, Precertification, Advanced Benefit Determination, etc.) and/or post-service claims.

Izervay may be considered **medically necessary** if the conditions indicated below are met.

Izervay may be considered **investigational** for all other indications.

Prior-Approval Requirements

Age 18 years of age or older

Diagnosis

Patient must have the following:

Geographic atrophy (GA) secondary to age-related macular degeneration (AMD)

AND ALL of the following:

a. Prescriber agrees to monitor for endophthalmitis, retinal detachment, and neovascular AMD
b. **NO** ocular or periocular infection
c. **NO** active intraocular inflammation

Prior – Approval *Renewal* Requirements

None

Policy Guidelines

Pre - PA Allowance

None

Prior - Approval Limits

Quantity 12 single-dose vials per affected eye

Duration 24 months

Prior – Approval *Renewal* Limits

None

Rationale

Summary

Izervay is indicated for the treatment of geographic atrophy secondary to age-related macular degeneration. Patients taking Izervay should be monitored for endophthalmitis and retinal detachments, neovascular AMD, and increased intraocular pressure. Izervay is contraindicated in patients with ocular or periocular infections and active intraocular inflammation (1).

Prior authorization is required to ensure the safe, clinically appropriate, and cost-effective use of Izervay while maintaining optimal therapeutic outcomes.

References

1. Izervay [package insert]. Northbrook, IL: Astellas Pharma US, Inc.; February 2024.

Policy History

Date	Action
September 2023	Addition to PA
December 2023	Annual review
March 2024	Annual review
March 2025	Annual editorial review and reference update. Removed no dual therapy with VEGF inhibitors for ocular indications requirement

Keywords

This policy was approved by the FEP® Pharmacy and Medical Policy Committee on March 7, 2025 and is effective on April 1, 2025.