Reference number(s)
7353-A

Standard Medicare Part B Management Yartemlea

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
Yartemlea	narsoplimab-wuug

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 Indications[1]

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).

All other indications will be assessed on an individual basis. Submissions for indications other than those listed in this criteria should be accompanied by supporting evidence from Medicare approved compendia.

Documentation

The following documentation must be available, upon request, for all submissions:

- For initial requests:
  - Chart notes or medical record documentation confirming the diagnosis of TA-TMA
  - Laboratory report confirming ADAMTS13 activity
- For continuation requests: Chart notes or medical record documentation supporting positive clinical response to therapy

© 2026 CVS Caremark. All rights reserved.

This document contains confidential and proprietary information of CVS Caremark and cannot be reproduced, distributed or printed without written permission from CVS Caremark. This document contains prescription brand name drugs that are trademarks or registered trademarks of pharmaceutical manufacturers that are not affiliated with CVS Caremark.

Reference number(s)
7353-A

Coverage Criteria

Transplant-Associated Thrombotic Microangiopathy (TA-TMA)[1]

Authorization of 6 months may be granted for the treatment of hematopoietic stem cell transplant-associated thrombotic microangiopathy (TA-TMA) when all of the following criteria are met:

- The member is 2 years of age or older
- Diagnosis has been confirmed by all of the following:
    - Platelet count < 150,000/μL
    - Evidence of microangiopathic hemolysis (presence of schistocytes, serum LDH greater than the upper limit of normal [ULN] and/or haptoglobin less than the lower limit of normal [LLN])
- The member has an ADAMTS13 activity level ≥10%
- The requested medication will not be used in combination with another complement inhibitor (e.g., Soliris, Ultomiris) or Defitelio (defibrotide)

Continuation of Therapy

All members (including new members) requesting authorization for continuation of therapy must be currently receiving therapy with the requested agent.

Authorization for 12 months may be granted when all of the following criteria are met:

- The member is currently receiving therapy with the requested medication.
- The requested medication is being used to treat an indication listed in the coverage criteria section.
- The requested medication is not being used in combination with another complement inhibitor (e.g., Soliris, Ultomiris) or Defitelio (defibrotide)
- The member is receiving benefit from therapy. Benefit is defined as:
    - No evidence of unacceptable toxicity while on the current regimen and
    - Improvement in platelet levels, normalization of lactate dehydrogenase (LDH) and haptoglobin levels

Summary of Evidence

The contents of this policy were created after examining the following resources:

- The prescribing information for Yartemlea.
- The available compendium
    - National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
    - Micromedex DrugDex

© 2026 CVS Caremark. All rights reserved.

This document contains confidential and proprietary information of CVS Caremark and cannot be reproduced, distributed or printed without written permission from CVS Caremark. This document contains prescription brand name drugs that are trademarks or registered trademarks of pharmaceutical manufacturers that are not affiliated with CVS Caremark.

- American Hospital Formulary Service- Drug Information (AHFS-DI)
- Lexi-Drugs
- Clinical Pharmacology

After reviewing the information in the above resources, the FDA-approved indications listed in the prescribing information for Yartemlea are covered.

Explanation of Rationale

Support for FDA-approved indications can be found in the manufacturer's prescribing information.

References

1. Yartemlea [package insert]. Seattle, WA: Omeros Corporation; December 2025.

© 2026 CVS Caremark. All rights reserved.

This document contains confidential and proprietary information of CVS Caremark and cannot be reproduced, distributed or printed without written permission from CVS Caremark. This document contains prescription brand name drugs that are trademarks or registered trademarks of pharmaceutical manufacturers that are not affiliated with CVS Caremark.