Reference number(s)
5794-A

Standard Medicare Part B Management Syfovre

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
Syfovre	pegcetacoplan

Indications

FDA-approved Indications[1]

Syfovre is indicated for the treatment of geographic atrophy (GA) secondary to age-related macular degeneration (AMD).

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:

- Initial Requests: Chart notes or medical records confirming the diagnosis of geographic atrophy (GA) secondary to age-related macular degeneration (AMD).
- Continuation Request: Chart notes or medical records confirming a positive clinical response to therapy.

Exclusions

Coverage will not be provided for the treatment of geographic atrophy (GA) secondary to a condition other than AMD (such as Stargardt disease, cone rod dystrophy, toxic maculopathies).

Coverage Criteria

© 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.

Geographic Atrophy (GA) Secondary to Age-related Macular Degeneration[1,2]

Authorization of 12 months may be granted for treatment of geographic atrophy when the member has a diagnosis of geographic atrophy secondary to age-related macular degeneration.

Continuation of Therapy

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

Authorization of 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 coverage criteria section.
- The member is receiving benefit from therapy (e.g., a reduction or stabilization in the rate of vision decline or the risk of more severe vision loss, stabilization or reduction in total area of GA lesions).

Summary of Evidence

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

- The prescribing information for Syfovre.
- The available compendium
    - National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
    - Micromedex DrugDex
    - American Hospital Formulary Service- Drug Information (AHFS-DI)
    - Lexi-Drugs
    - Clinical Pharmacology
- Age-Related Macular Degeneration Preferred Practice Pattern 2024.

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

Explanation of Rationale

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

References

1. Syfovre [package insert]. Waltham, MA: Apellis Pharmaceuticals Inc; July 2025.
2. Age-Related Macular Degeneration PPP 2024. American Academy of Ophthalmology. Published February 2025. Accessed December 9, 2025. https://www.aao.org/education/preferred-practice-pattern/age-related-macular-degeneration-ppp.

© 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.