Reference number(s)
6106-A

Standard Medicare Part B Management Izervay

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
Izervay	avancincaptad pegol

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]

Izervay 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:

Chart notes or medical records confirming the diagnosis of geographic atrophy (GA) secondary to age-related macular degeneration (AMD).

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Exclusions

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

Coverage Criteria

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

Authorization of 12 months may be granted for treatment 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 in the coverage criteria section.
- The member is receiving benefit from therapy (e.g., improvement or maintenance in best corrected visual acuity [BCVA] or vision field, or a reduction in the rate of vision decline or the risk of more severe vision loss).

Summary of Evidence

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

- The prescribing information for Izervay.
- 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

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- 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 Izervay are covered.

Explanation of Rationale

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

References

1. Izervay [package insert]. Parsippany, NJ: Iveric Bio Inc; March 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.

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