Clinical Policy: Narsoplimab-wuug (Yartemlea)

Reference Number: PA.CP.PHAR.527
Effective Date: 05/2026
Last Review Date: 04/2026

Description
Narsoplimab-wuug (Yartemlea™) is a mannan-binding lectin-associated serine protease-2 (MASP-2) inhibitor.

FDA Approved Indication(s)
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).

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of PA Health & Wellness® that Yartemlea is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Hematopoietic Stem Cell Transplant-Associated Thrombotic Microangiopathy (must meet all)**:**

1. Diagnosis of hematopoietic stem cell TA-TMA;
2. Prescribed by or in consultation with a hematologist or transplant specialist;
3. Age ≥ 2 years;
4. Member has signs of persistent TMA as evidenced by presence of all of the following for at least 2 weeks after modification or discontinuation of calcineurin inhibitor therapy (e.g., cyclosporine, tacrolimus) (a, b, and c):
   a. Platelet count < 150 x 10^9/L;
   b. Evidence of hemolysis (e.g., serum lactate dehydrogenase [LDH] above the upper limit of normal, presence of schistocytes);
   c. One of the following (i or ii)
      i. Serum creatinine ≥ 2 times pre-transplantation baseline, member requires dialysis or random urine protein to creatinine ratio ≥ 1mg/mg;
      ii. Seizures, altered mental status, visual changes/cortical blindness with infection ruled out;
5. Documentation that member does not have any of the following (a, b, and c):
   a. A disintegrin and metalloproteinase with thrombospondin type 1 motif, member 13 (ADAMTS13) deficiency;
   b. Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS);
   c. Atypical hemolytic uremic syndrome (aHUS);
6. Yartemlea is not prescribed concurrently with Soliris®/Bkemv™/Epysqli® or Ultomiris®;
7. Member has not received Yartemlea for > 16 weeks;
8. Dose does not exceed one of the following (a or b):

a. Weight ≥ 50 kg: 370 mg once weekly;
b. Weight < 50 kg: 4 mg/kg once weekly.

Approval duration: 8 weeks

B. Other diagnoses/indications

1. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): PA.CP.PMN.53

II. Continued Therapy

A. Hematopoietic Stem Cell Transplant-Associated Thrombotic Microangiopathy (must meet all)**:**

1. Currently receiving medication via PA Health & Wellness benefit and documentation supports positive response to therapy or the Continuity of Care policy (PA.PHARM.01) applies;
2. Member is responding positively to therapy as evidenced by, including but not limited to, improvement in any of the following parameters (a, b, c, or d):
   a. Improved measures of hemolysis (e.g., normalization of LDH, decrease or absence of schistocytes);
   b. Increased or stabilized platelet counts;
   c. Improved or stabilized serum creatinine or estimated glomerular filtration rate (eGFR);
   d. Reduced need for dialysis;
3. Member has not received Yartemlea for > 16 weeks;
4. Yartemlea is not prescribed concurrently with Soliris/Bkemv/Epysqli or Ultomiris;
5. If request is for a dose increase, new dose does not exceed one of the following (a or b):
   a. Weight ≥ 50 kg: 370 mg twice weekly;
   b. Weight < 50 kg: 4 mg/kg twice weekly.

Approval duration: Up to 16 weeks total

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via PA Health & Wellness benefit and documentation supports positive response to therapy or the Continuity of Care policy (PA.PHARM.01) applies.
   Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): PA.CP.PMN.53

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – PA.CP.PMN.53

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
LDH: lactate dehydrogenase

MASP-2: mannan-binding lectin-associated serine protease-2

TA-TMA: transplant-associated thrombotic microangiopathy

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings
None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
TA-TMA	Administer as an IV infusion once weekly with weight-based dosing: • ≥ 50 kg: 370 mg IV once weekly • < 50 kg: 4 mg/kg IV once weekly Increase frequency to twice weekly if there is inadequate improvement in TA-TMA signs and symptoms.	See regimen

VI. Product Availability

Solution for injection in single-dose vial: 370 mg/2 mL

VII. References

1. Yartemlea Prescribing Information. Seattle, WA: Omeros; December 2025. Available at: https://pi.omeros.com/us/yartemlea-uspi.pdf. Accessed February 22, 2026.
2. Khaled SK, Claes K, Goh YT, et al. Narsoplimab, a mannan-binding lectin-associated serine protease-2 inhibitor, for the treatment of adult hematopoietic stem-cell transplantation-associated thrombotic microangiopathy. J Clin Oncol. 2022;40(22):2447-2457.
3. Schoettler ML, Carreras E, Cho B, et al. Harmonizing definitions for diagnostic criteria and prognostic assessment of transplantation-associated thrombotic microangiopathy: A report on behalf of the European Society for Blood and Marrow Transplantation, American Society for Transplantation and Cellular Therapy, Asia-Pacific Blood and Marrow Transplantation Group, and Center for International Blood and Marrow Transplant Research. Transplant Cell Ther. 2023;29(3):151-163.
4. Schoettler ML, Gavriilaki E, Carreras E, et al. An ASTCT, CIBMTR, EBMT, and APBMT consensus statement defining response criteria for hematopoietic cell transplantation associated thrombotic microangiopathy (TA-TMA) directed therapy. Transplant Cell Ther. 2025;31(9):610-623.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
C9399	Unclassified drugs or biologicals
J3590	Unclassified biologics

Reviews, Revisions, and Approvals	Date
Policy created	04/2026