Policy Title:	Uplizna (inebilizumab-cdon) (Intravenous)		
		Department:	PHA
Effective Date:	12/01/2020		
Review Date:	11/2/2020, 7/15/2021, 7/7/2022, 4/27/2023, 12/14/2023, 01/04/2024		

Purpose: To support safe, effective, and appropriate use of Uplizna (inebilizumab-cdon).

Scope: Medicaid, Commercial, Medicare-Medicaid Plan (MMP)

Policy Statement:
Uplizna (inebilizumab-cdon) is covered under the Medical Benefit when used within the following guidelines. Use outside of these guidelines may result in non-payment unless approved under an exception process.

Procedure:
Coverage of Uplizna will be reviewed prospectively via the prior authorization process based on criteria below.

Initial Criteria:

MMP members who have previously received this medication within the past 365 days are not subject to Step Therapy Requirements.

- Patient is 18 years or older; AND
- Prescribed by, or in consultation with, a neurologist; AND
- Patient has been evaluated and screened for the presence of hepatitis B virus (HBV) prior to initiating treatment and confirmed negative for active HBV; AND
- Patient serum immunoglobulin baseline measured prior to the start of therapy; AND
- Patient does not have an underlying immunodeficiency disorder (i.e., acquired/congenital primary immunodeficiency, HIV, etc.); AND
- Patient has not received any vaccinations in the 4-weeks prior to the start of therapy; AND
- Patient has been evaluated and screened for the presence of latent TB infection prior to initiating treatment and will receive ongoing monitoring for presence of TB during treatment; AND
- Patient does not have an active infection, including clinically important localized infections; AND
- Will not be administered concurrently with live or live-attenuated vaccines; AND
- Patient is not concomitantly receiving therapy with other immunosuppressant type drugs [i.e., alemtuzumab, natalizumab, cyclosporine, methotrexate, mitoxantrone, cyclophosphamide, tocilizumab, maintenance corticosteroids (not including pre-medications

or rescue therapy), etc.] or other immunosuppressant procedures (i.e., total lymphoid irradiation, bone marrow transplant, etc.); AND

- Will not be used in combination with a complement-inhibitor (i.e., eculizumab, ravulizumab) or anti-CD20-directed antibody (i.e., rituximab) or IL-6 inhibitor (e.g., satralizumab) therapies; AND
- Patient has experienced a failure, contraindication, or intolerance to Enspryng (satralizumab)*
  * This requirement **ONLY** applies to **Medicaid** Members

Neuromyelitis Optica Spectrum Disorder (NMOSD)

- Submission of medical records (e.g., chart notes, laboratory values, etc.) to support the diagnosis of neuromyelitis optica spectrum disorder (NMOSD) by a neurologist confirming all the following:
  - Past medical history of one of the following:
    - Optic neuritis
    - Acute myelitis
    - Area postrema syndrome: episode of otherwise unexplained hiccups or nausea and vomiting
    - Acute brainstem syndrome
    - Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions
    - Symptomatic cerebral syndrome with NMOSD-typical brain lesions; AND
  - Positive serologic test for anti-aquaporin-4 immunoglobulin G (AQP4-IgG)/NMO-IgG antibodies; AND
  - Diagnosis of multiple sclerosis or other diagnoses have been ruled out; AND

- Patient has a history of one or more relapses that required rescue therapy within the year prior to screening, or 2 or more relapses that required rescue therapy in 2 years prior to screening; AND
- Patient has an Expanded Disability Status Score (EDSS) of ≤ 7.5 (i.e., inability to take more than a few steps; restricted to wheelchair and may need aid in transferring; can wheel self but cannot carry on in standard wheelchair for a full day and may require a motorized wheelchair)

Core Clinical Characteristics of NMOSD
• Optic neuritis • Acute myelitis • Area postrema syndrome: episode of otherwise unexplained hiccups or nausea and vomiting • Acute brainstem syndrome • Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions • Symptomatic cerebral syndrome with NMOSD-typical brain lesions

Continuation of Therapy Criteria:

- Patient continues to meet universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; AND
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include the following: serious or life-threatening infusion related reactions, serious infections including PML, hypogammaglobulinemia necessitation IVIG or leading to recurrent infections, etc.; AND
- Disease response as indicated by stabilization/improvement in any of the following: neurologic symptoms as evidenced by a decrease in acute relapses, stability or improvement in EDSS, reduced hospitalizations, and/or reduction in plasma exchange treatments

Coverage durations:

- Initial coverage: 6 months
- Continuation of therapy coverage: 12 months

Per §§ 42 CFR 422.101, this clinical medical policy only applies to INTEGRITY in the absence of National Coverage Determination (NCD) or Local Coverage Determination (LCD).

Dosage/Administration:

Indication	**Dose**	**Maximum dose (1 billable unit = 1 mg)**
Neuromyelitis Optica Spectrum Disorder (NMOSD)	Uplizna is administered as an intravenous infusion, as follows: • Initial dose: 300 mg IV infusion followed 2 weeks later by a second 300 mg IV infusion. • Subsequent doses (starting 6 months from the first infusion): single 300 mg IV infusion every 6 months.	300 units on days 1, 15 and then 300 units every 6 months thereafter

Investigational use: All therapies are considered investigational when used at a dose or for a condition other than those that are recognized as medically accepted indications as defined in any one of the following standard reference compendia: American Hospital Formulary Service Drug information (AHFS-DI), Thomson Micromedex DrugDex, Clinical Pharmacology, Wolters Kluwer Lexi-Drugs, or Peer-reviewed published medical literature indicating that sufficient evidence exists to support use. Neighborhood does not provide coverage for drugs when used for investigational purposes.

Applicable Codes:
Below is a list of billing codes applicable for covered treatment options. The below tables are provided for reference purposes and may not be all-inclusive. Requests received with codes from tables below do not guarantee coverage. Requests must meet all criteria provided in the procedure section.

The following HCPCS/CPT codes are:

HCPCS/CPT Code	Description
J1823	injection, inebilizumab-cdon, 1mg

References:

1. Uplizna [package insert]. Gaithersburg, MD; Viela Bio, Inc; July 2021. Accessed November 2022.
2. Cree BAC, Bennett JL, Kim HJ, et al; N-MOmentum study investigators. Inebilizumab for the treatment of neuromyelitis optica spectrum disorder (N-MOmentum): a double-blind, randomised placebo-controlled phase 2/3 trial. Lancet. 2019 Oct 12;394(10206):1352-1363. doi: 10.1016/S0140-6736(19)31817-3. Epub 2019 Sep 5.
3. Trebst C, Jarius S, Berthele A, et al. Update on the diagnosis and treatment of neuromyelitis optica: recommendations of the Neuromyelitis Optica Study Group (NEMOS). J Neurol 2014; 261:1.
4. Wingerchuk DM, Banwell B, Bennett JL, et al. International consensus diagnostic criteria for neuromyelitis optica spectrum disorders. Neurology. 2015 Jul;85(2):177-89. Epub 2015 Jun 19.