Uplizna (inebilizumab-cdon)

NOTICE

This policy contains information which is clinical in nature. The policy is not medical advice. The information in this policy is used by Wellmark to make determinations whether medical treatment is covered under the terms of a Wellmark member's health benefit plan. Physicians and other health care providers are responsible for medical advice and treatment. If you have specific health care needs, you should consult an appropriate health care professional. If you would like to request an accessible version of this document, please contact customer service at 800-524-9242.

BENEFIT APPLICATION

Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This medical policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

DESCRIPTION

The intent of the Uplizna (inebilizumab-cdon) drug policy is to ensure appropriate selection of patients for therapy based on product labeling, clinical guidelines, and clinical studies. The indications below including FDA-approved indications and compendial uses are considered covered benefits provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

Uplizna is indicated for the treatment of neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive.

POLICY

Required Documentation

Submission of the following information is necessary to initiate the prior authorization review:

- Immunoassay used to confirm anti-aquaporin-4 (AQP4) antibody is present
- For continuation of therapy request: medical records (e.g., chart notes, laboratory tests) demonstrating positive clinical response from baseline

Criteria for Initial Approval

A. Uplizna (inebilizumab-cdon) may be considered **medically necessary** for the treatment of neuromyelitis optica spectrum disorder (NMOSD) in adults when all of the following criteria are met:
   1. Member is anti-aquaporin-4 (AQP4) antibody positive
   2. The medication is being prescribed by, or in consultation with, a neurologist
   3. Member exhibits one of the following core clinical characteristics of NMOSD:

a. Optic neuritis
b. Acute myelitis
c. Area postrema syndrome (episode of otherwise unexplained hiccups or nausea and vomiting)
d. Acute brainstem syndrome
e. Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic magnetic resonance imaging (MRI) lesions
f. Symptomatic cerebral syndrome with NMOSD-typical brain lesions

4. Member has a history of one of the following:
    a. One or more relapses that required rescue therapy within the previous 12 months prior to initiating therapy
    b. Two or more relapses that required rescue therapy within the previous 24 months prior to initiating therapy
5. Member has had an inadequate response, intolerable adverse event, or documented contraindication to rituximab therapy AND Enspryng (satralizumab-mwge) therapy.
6. The member will not receive the requested drug concomitantly with any of the following:
    a. Complement-inhibitors (i.e., eculizumab, ravulizumab)
    b. Anti-CD20 therapy (i.e., rituximab)
    c. IL-6 receptor antagonist (i.e., satralizumab-mwge)

Approval will be for up to **6 months**

Continuation of Therapy
Uplizna (inebilizumab-cdon) may be considered **medically necessary** for the continued treatment of neuromyelitis optica spectrum disorder (NMOSD) in adults who are anti-aquaporin-4 (AQP4) antibody positive when the medication is being prescribed by, or in consultation with, a neurologist and the member demonstrates a positive clinical response to therapy from baseline as demonstrated by, a reduction or maintained reduction, in the number and/or severity of relapses.

Approval will be for **12 months**

Uplizna is considered **not medically necessary** for members who do not meet the criteria set forth above.

Other
Prior to initiation of therapy, all individuals should receive HBV screening, TB screening, and quantitative serum immunoglobulin testing. Individuals should also receive all immunizations according to guidelines at least 4 weeks prior to initiating therapy for live or live-attenuated vaccines.

Dosage and Administration
Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Quantity Limits

Trade Name	Generic Name	Quantity Limit
Uplizna®	Inebilizumab-cdon	Initiation of therapy: 3 vials (300mg) once followed by 3 vials (300 mg) two weeks later Maintenance: 3 vials (300mg) every 6 months

CLINICAL RATIONALE

Background

Neuromyelitis optica spectrum disorder (NMOSD) is a rare, autoimmune, demyelinating disease of the central nervous system (CNS) that may be severely disabling and life-threatening. Patients with NMOSD most commonly present with either optic neuritis or transverse myelitis. Many patients experience severe relapses which often cause marked disability early in the course of illness, with unpredictable relapses causing cumulative, permanent, neurological damage and disability. Recovery from the attacks is often incomplete, resulting in residual and accumulating impairment, such as blindness and paralysis. Patients also can lose bladder and bowel control, suffer nerve pain and experience respiratory failure. Since disability progression in NMOSD is primarily due to consequences of attacks, the goals of pharmacotherapy are to aggressively treat acute inflammatory attacks and prevent future relapses, minimize CNS damage, and ultimately preserve neurological function. The best evidence for maintenance therapy is off label immunosuppressive therapies including rituximab, mycophenolate mofetil, and azathioprine with prednisone when necessary. Treatment with these agents was associated with significant reductions in annualized relapse rates in the range of 72%-88%. Uplizna follows the approval of Soliris in 2019, which was the first drug to receive FDA approval for NMSOD. Enspryng, the first self-administered agent for NMOSD, received FDA approval following Uplizna, and is the third agent approved for NMOSD. Uplizna is a CD19-directed cytolytic antibody and is given via intravenous infusion every 6 months.

Efficacy

The FDA approval of Uplizna was based on data from the N-Momentum clinical trial. The trial was a double-blind, randomized, placebo-controlled trial over 197 days in which 230 adult patients with NMOSD were randomized to Uplizna or placebo. In the trial, 213 of the 230 patients were anti-aquaporin-4 (AQP4) antibody positive. The primary endpoint was time to onset of an NMOSD attack. A NMOSD attack occurred in 12% of patients in the Uplizna (inebilizumab-cdon) group vs. 39% of patients in the placebo group. The AQP4-IgG-positive subgroup had similar results with 11% of patients in the Uplizna (inebilizumab-cdon) group experiencing an attack vs. 42% of patients in the placebo group. Overall, the risk of an NMOSD relapse in the 161 anti-AQP4 antibody positive patients who were treated with Uplizna was reduced by 77% compared to the placebo treatment group. There was no evidence of benefit in patients who were anti-AQP4 antibody negative. Of note, the randomized, controlled period was terminated early before complete enrollment due to clear demonstration of efficacy.

Safety

Uplizna is contraindicated in patients with active hepatitis B infection and active or untreated latent tuberculosis. Uplizna can cause infusion reactions, an increased risk of infection, hypogammaglobulinemia, and fetal risk. The most common adverse effects in the clinical trial were urinary tract infection (20%), nasopharyngitis (13%), headache (10%), arthralgia (11%), nausea and back pain (7%). Vaccination with live attenuated or live vaccines is not recommended during treatment and after discontinuation, until B-cell repletion.

PROCEDURES AND BILLING CODES

To report provider services, use appropriate CPT* codes, Alpha Numeric (HCPCS level 2) codes, Revenue codes, and/or ICD diagnostic codes.

- J1823 - Injection, inebilizumab-cdon, 1 mg

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POLICY HISTORY

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