



Drug Coverage Policy

Effective Date..... 08/01/2024
Coverage Policy Number..... IP0062
Policy Title..... Uplizna

Uplizna

- Uplizna® (inebilizumab-cdon intravenous infusion – Horizon Therapeutics)

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer’s particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer’s benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer’s benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment and have discretion in making individual coverage determinations. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Cigna Healthcare Coverage Policy

OVERVIEW

Uplizna, a CD19-directed cytolytic antibody, is indicated for the treatment of **neuromyelitis optica spectrum disorder** (NMOSD) in adults who are anti-aquaporin-4 antibody-positive.¹ The recommended dose is 300 mg administered as an intravenous (IV) infusion under the close supervision of an experienced healthcare professional. The initial infusion is followed 2 weeks later by a second 300 mg IV infusion. Subsequent doses are administered once every 6 months (starting 6 months after the first infusion).

Disease Overview

NMOSD is a rare, relapsing, autoimmune central nervous system inflammatory disorder that can lead to significant morbidity and mortality.^{2,3} The predominant symptoms are inflammation of the optic nerve (optic neuritis) and inflammation of the spinal cord (myelitis). Optic neuritis may lead

to pain inside the eye and can progress to blindness. Myelitis tends to affect some, and often all, motor, sensory, and autonomic functions (bladder and bowel). Affected patients may experience pain in the spine or limbs, mild to severe paralysis of the lower limbs, and loss of bowel and bladder control.

The Neuromyelitis Optica Study Group (NEMOS) published revised recommendations for the treatment of NMOSD in 2024.⁴ The standard of care for the treatment of NMOSD attacks (for both AQP4-IgG-positive and double-negative cases) are high-dose glucocorticoids and/or apheresis therapy. Long term immunotherapy is recommended for patients with AQP4-IgG-positive NMOSD. NEMOS notes the first-choice therapies for the treatment of AQP4-IgG-positive NMOSD are Uplizna, Enspryng® (satralizumab-mwge subcutaneous injection), Soliris® (eculizumab intravenous infusion), Ultomiris® (ravulizumab-cwyz intravenous infusion), and rituximab. The order of preference for these therapies is unclear and further comparative trials and real-world data are needed. The choice of treatment is dependent on several factors, including disease activity and severity, mode and onset of action, possibility to combine it with immunosuppressive drugs, effect on autoimmune and other comorbidities, gender (family planning issues), frequency and route of administration, side effect profile as well as patient and physician preference. In general, if a patient fails a first-choice treatment, another first-choice treatment should be tried; other options include use of a second-choice treatment (azathioprine, mycophenolate mofetil, low-dose oral glucocorticoids) or the addition of a second-choice treatment to the regimen.

Medical Necessity Criteria

Uplizna is considered medically necessary when the following criteria are met:

FDA-Approved Indication

- 1. Neuromyelitis Optica Spectrum Disorder.** Approve if the patient meets ONE of the following (A or B):
 - A) Initial Therapy.** Approve for 1 year if the patient meets ALL of the following (i, ii, and iii):
 - i.** Patient is ≥ 18 years of age; AND
 - ii.** Diagnosis of neuromyelitis optica spectrum disorder was confirmed by blood serum test for anti-aquaporin-4 antibody positive disease; AND
 - iii.** The medication is being prescribed by or in consultation with a neurologist.
 - B) Patient is Currently Receiving Uplizna.** Approve for 1 year if the patient meets ALL of the following (i, ii, iii, and iv):
 - i.** Patient is ≥ 18 years of age; AND
 - ii.** Diagnosis of neuromyelitis optica spectrum disorder was confirmed by blood serum test for anti-aquaporin-4 antibody positive disease; AND
 - iii.** According to the prescriber, patient has had clinical benefit from the use of Uplizna; AND
Note: Examples of clinical benefit include reduction in relapse rate, reduction in symptoms (e.g., pain, fatigue, motor function), and a slowing progression in symptoms.
 - iv.** The medication is being prescribed by or in consultation with a neurologist.

Dosing. Approve ONE of the following dosing regimens (A or B):

- A)** 300 mg by intravenous infusion once every 2 weeks for two doses; OR
- B)** 300 mg by intravenous infusion once every 6 months.

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Conditions Not Covered

Any other use is considered experimental, investigational, or unproven, including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. **Concomitant Use With a Rituximab Product, Enspryng (satralizumab-mwge subcutaneous injection), or Soliris (eculizumab intravenous infusion), or Ultomiris (ravulizumab-cwyz intravenous infusion.** There is no evidence to support additive efficacy of combining Uplizna with rituximab, Enspryng, Soliris, or Ultomiris Intravenous.

Coding Information

- 1) This list of codes may not be all-inclusive.
- 2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

HCPCS Codes	Description
J1823	Injection, inebilizumab-cdon, 1 mg

***Current Procedural Terminology (CPT®) ©2020 American Medical Association: Chicago, IL.**

References

1. Uplizna® intravenous infusion [prescribing information]. Deerfield, IL: Horizon Therapeutics; July 2021.
2. National Organization for Rare Disorders. Neuromyelitis Optica Spectrum Disorder. Last updated July 27, 2022. Available at: <https://rarediseases.org/rare-diseases/neuromyelitis-optica/>. Accessed on April 5, 2024.
3. Chan KH, Lee CY. Treatment of neuromyelitis optica spectrum disorders. *Int J Mol Sci.* 2021;22(16):8638.
4. Kúmpfel T, Gighuber K, Aktas O, et al. Update on the diagnosis and treatment of neuromyelitis optica spectrum disorders (NMOSD) – revised recommendations of the Neuromyelitis Optica Study Group (NEMOS). Part II: Attack therapy and long-term management. *J Neurol.* 2024;271:141-176.

Revision Details

Type of Revision	Summary of Changes	Date
Annual Revision	Policy Name Change: Updated Policy Name from "Inebilizumab" to "Uplizna."	08/01/2024

	<p>Neuromyelitis Optica Spectrum Disorder: Added note with examples of clinical benefit from use of Uplizna. Conditions Not Covered: Ultomiris (ravulizumab-cwyz intravenous infusion) received FDA approval for treatment of NMOSD and was added to the criterion "Concomitant Use with a Rituximab Product, Enspryng (satralizumab-mwge subcutaneous injection), or Soliris (eculizumab intravenous infusion)."</p>	
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The policy effective date is in force until updated or retired.

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