



Wellmark Blue Cross and Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association.

DRUG POLICY

Veopoz (pozelimab-bbfg)

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 Veopoz (pozelimab-bbfg) policy is to provide coverage consistent with product labeling, FDA guidance, standards of medical practice, evidence-based drug information, and/or published guidelines. 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

Veopoz (pozelimab-bbfg) is indicated for the treatment of adult and pediatric patients 1 year of age and older with complement hyperactivation, angiopathic thrombosis, and protein-losing enteropathy (CHAPLE) disease, also known as CD55-deficient protein-losing enteropathy (PLE).

POLICY

Required Documentation

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

- A. For initial requests: Chart notes, medical records, or claims history documenting:
 - a. Genetic testing confirming CD55 loss-of function mutation
- B. For continuation requests: Chart notes or medical record documentation supporting a positive clinical response to therapy:
 - a. Improvement or stabilization in disease activity (e.g., improvement of clinical symptoms [abdominal pain, diarrhea, and/or edema], increase in or stabilization of IgG concentrations, increase in growth percentiles, reduction in hospitalizations)
 - b. Normalization of serum albumin levels

Prescriber Requirements

This medication must be prescribed by or in consultation with a provider who specializes in the treatment of CHAPLE disease.

Criteria for Initial Approval

Complement Hyperactivation, Angiopathic Thrombosis, and Protein-Losing Enteropathy (CHAPLE)

Authorization of 6 months may be granted for treatment of CHAPLE disease when all of the following criteria are met:

- A. Member is 1 year of age or older.
- B. Member has a diagnosis of CD55-deficient protein-losing enteropathy (PLE), also known as CHAPLE disease confirmed by biallelic CD55 loss-of-function mutation detected by genetic testing.
- C. Member has active disease defined as hypoalbuminemia (serum albumin concentration ≤ 3.2 g/dL) with one or more of the following in the last 6 months:
 - a. Abdominal pain
 - b. Vomiting
 - c. Diarrhea
 - d. Peripheral or facial edema
 - e. Infection with concomitant hypogammaglobinemia
 - f. New thromboembolic event
- D. Member will not receive the requested drug in combination with another complement inhibitor.
- E. Member has adequate titers or will receive meningococcal vaccines at least two weeks prior to the first dose of Veopoz.

Continuation of Therapy

Complement Hyperactivation, Angiopathic Thrombosis, and Protein-Losing Enteropathy (CHAPLE)

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization when the following criteria are met:

- A. There is no evidence of unacceptable toxicity or disease progression while on the current regimen
- B. Member demonstrates a positive response to therapy as defined by ALL of the following:
 - a. Improvement or stabilization in disease activity (e.g., improvement of clinical symptoms [abdominal pain, diarrhea, and/or edema], increase in or stabilization of IgG concentrations, increase in growth percentiles, reduction in hospitalizations)
 - b. Normalization of serum albumin levels

Veopoz (pozelimab-bbfg) is considered **not medically necessary** for members who do not meet the criteria set forth above.

Dosing and Administration

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

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.

- J9376 – Injection, pozelimab-bbfg, 1 mg (effective 4/1/24)
- J3590 – unclassified biologics
- J3490 – unclassified drugs
- C9399 – unclassified drugs or biologics (hospital outpatient use)

REFERENCES

- Veopoz [package insert]. Tarrytown, NY: Regeneron Pharmaceuticals, Inc.; August 2023.

POLICY HISTORY

Policy #: 05.05.14

Original Effective Date: December 7, 2023

Reviewed: October 2025

Revised:

Current Effective Date: December 7, 2023