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.
- Immunoglobulin G4-related disease (IgG4-RD) in adult patients.
- Generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (MuSK) antibody positive.

POLICY

Required Documentation

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

Neuromyelitis optica spectrum disorder (NMOSD)

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

Immunoglobulin G4-related disease (IgG4-RD)

- For initial requests, chart notes or medical records documenting:

- Member has a clinical diagnosis of IgG4-RD
- Member is experiencing an IgG4-RD flare requiring glucocorticoid treatment (within the past 4 weeks)
- IgG4-RD is affecting at least 1 organ/site

- For continuation requests: Chart notes or medical record documentation supporting positive clinical response

Generalized myasthenia gravis

- For initial requests: Chart notes, medical records, or claims history documenting:
  - Positive anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (MuSK) antibody test
  - Myasthenia Gravis Foundation of America (MGFA) clinical classification
  - MG activities of daily living score (MG-ADL)
  - Use of an acetylcholinesterase (AChE) inhibitor, steroid, non-steroidal immunosuppressive therapy (NSIST), and/or intravenous immunoglobulin (IVIG) where applicable
  - Prior chronic treatment with plasmapheresis or plasma exchange (if applicable)
- For continuation requests: Chart notes or medical record documentation supporting positive clinical response

Criteria for Initial Approval

Neuromyelitis optica spectrum disorder (NMOSD)

1. 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:
   A. Member is anti-aquaporin-4 (AQP4) antibody positive
   B. The medication is being prescribed by, or in consultation with, a neurologist
   C. Member exhibits one of the following core clinical characteristics of NMOSD:
      i. Optic neuritis
      ii. Acute myelitis
      iii. Area postrema syndrome (episode of otherwise unexplained hiccups or nausea and vomiting)
      iv. Acute brainstem syndrome
      v. Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic magnetic resonance imaging (MRI) lesions
      vi. Symptomatic cerebral syndrome with NMOSD-typical brain lesions
   D. Member has a history of one of the following:
      i. One or more relapses that required rescue therapy within the previous 12 months prior to initiating therapy
      ii. Two or more relapses that required rescue therapy within the previous 24 months prior to initiating therapy
   E. Member has had an inadequate response, intolerable adverse event, or documented contraindication to rituximab therapy AND Enspryng (satralizumab-mwge) therapy.
   F. The member will not receive the requested drug concomitantly with any of the following:
      i. Complement-inhibitors (i.e., eculizumab, ravulizumab)
      ii. Anti-CD20 therapy (i.e., rituximab)
      iii. IL-6 receptor antagonist (i.e., satralizumab-mwge)

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

Immunoglobulin G4-related disease (IgG4-RD)

1. Uplizna (inebilizumab-cdon) may be considered **medically necessary** for the treatment of Immunoglobulin G4-related disease (IgG4-RD)in adults when all of the following criteria are met:
   A. Member has a clinical diagnosis of IgG4-RD confirmed by either of the following (please see Appendix A for evaluations and characteristic organs to confirm diagnosis):

i. Clinical or radiologic involvement of a characteristic organ.
ii. Pathologic evidence from a characteristic organ.

B. Alternative causes of member's clinical signs and symptoms have been evaluated and ruled out (please see Appendix B for common mimickers of IgG4-RD).
C. Member is experiencing an IgG4-RD flare that requires initiation or continuation of glucocorticoid treatment (within the past 4 weeks).
D. Member has a history of IgG4-RD affecting at least 1 organ/site at any time in the course of IgG4-RD.

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

Generalized myasthenia gravis (gMG)

1. Uplizna (inebilizumab-cdon) may be considered **medically necessary** for the treatment of generalized myasthenia gravis (gMG) in adults when all of the following criteria are met:
   A. Member is anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (MuSK) antibody positive
   B. Member has Myasthenia Gravis Foundation of America (MGFA) clinical classification II to IV
   C. Member has a MG activities of daily living (MG-ADL) total score of 5 or more
   D. Member had an inadequate response with two or more conventional therapies (e.g., pyridostigmine, corticosteroids, immunosuppressant such as azathioprine, cyclosporine, mycophenolate, etc.) OR member required chronic treatment with plasmapheresis, plasma exchange (PE) or intravenous immunoglobulin (IVIG) in addition to immunosuppressant therapy
   E. Member is on a stable dose of at least one of the following:
      i. Acetylcholinesterase inhibitors (e.g., pyridostigmine)
      ii. Steroids (at least 1 month of treatment)
      iii. Nonsteroidal immunosuppressive therapy (NSIST) (at least 6 months of treatment) (e.g., azathioprine, mycophenolate mofetil)

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

Continuation of Therapy

Neuromyelitis optica spectrum disorder (NMOSD)

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

Immunoglobulin G4-related disease (IgG4-RD)

1. Uplizna (inebilizumab-cdon) may be considered **medically necessary** for the continued treatment of Immunoglobulin G4-related Disease (IgG4-RD) when all of the following criteria are met:
   A. There is no evidence of unacceptable toxicity or disease progression while on the current regimen.
   B. The member demonstrates a positive response to therapy (e.g., reduction in IgG4-RD flares).

Approval will be for **12 months**

Generalized myasthenia gravis (gMG)

1. Uplizna (inebilizumab-cdon) may be considered **medically necessary** for the continued treatment of generalized myasthenia gravis (gMG) when the member demonstrates a positive response to therapy (e.g., improvement in MG-ADL score, changes compared to baseline in Quantitative Myasthenia Gravis [QMG] total score).

   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 (300 mg) once followed by 3 vials (300 mg) two weeks later Maintenance: 3 vials (300 mg) every 6 months

Appendix

Appendix A: Adapted from the 2020 Revised Comprehensive Diagnostic Criteria for IgG4-RD and the 2019 ACR/EULAR Classification Criteria for IgG4-RD

- Clinical or radiological features:
  - One or more organs show diffuse or localized swelling or a mass or nodule characteristic of IgG4-RD. In single organ involvement, lymph node swelling is omitted.
  - Note: Nearly any organ can be affected, but characteristic organs involved include:
    - Pancreas
    - Salivary gland
    - Bile ducts
    - Orbits
    - Kidney
    - Lung
    - Aorta
    - Retroperitoneum
    - Pachymeninges
    - Thyroid gland (Riedel's thyroiditis)
- Pathological diagnosis (positivity for two of the following three criteria):
  - Dense lymphocyte and plasma cell infiltration with fibrosis.
  - Ratio of IgG4-positive plasma cells /IgG-positive cells greater than 40% and the number of IgG4-positive plasma cells greater than 10 per high powered field.
  - Typical tissue fibrosis, particularly storiform fibrosis, or obliterative phlebitis.

Appendix B: Common Mimickers of IgG4-RD

- Malignancy
- Vasculitis
- Sjogren's syndrome
- Primary granulomatous inflammation (including sarcoidosis)
- Infection
- Multicentric Castleman's disease
- Erdheim-Chester disease
- Crohn's disease or ulcerative colitis (if only pancreatobiliary disease is present)
- Hashimoto thyroiditis (if only the thyroid is affected)

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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