Uplizna® (Inebilizumab-Cdon)

Policy Number: CS2022D0091G
Effective Date: August 1, 2022

Instructions for Use

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Commercial Policy
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Application

This Medical Benefit Drug Policy does not apply to the states listed below; refer to the state-specific policy/guideline, if noted:

State	Policy/Guideline
Indiana	Refer to state Medicaid clinical policy
Kansas	Refer to state Medicaid clinical policy
Louisiana	Uplizna® (Inebilizumab-Cdon) (for Louisiana Only)
North Carolina	None
Texas	Refer to drug-specific criteria found within the Texas Medicaid Provider Procedures Manual

Coverage Rationale

Uplizna (inebilizumab-cdon) is proven and medically necessary for the treatment of neuromyelitis optica spectrum disorder (NMOSD) when all of the following criteria are met:

Initial Therapy

- 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 of the following:[1-4]
  - 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

- One of the following:[7-14]
  - History of failure of rituximab therapy; or
  - Both of the following:
    - History of intolerance or contraindication to rituximab; and
    - Physician attests that, in their clinical opinion, the same intolerance or severe adverse event would not be expected to occur with Uplizna;

  and
- One of the following:[5]
  - History of one or more relapses that required rescue therapy during the previous 12 months prior to initiating Uplizna
  - History of two or more relapses that required rescue therapy during the previous 24 months, prior to initiating Uplizna;

  and
- Uplizna is initiated according to the U.S. Food and Drug Administration (FDA) labeled dosing for NMOSD; and
- Prescribed by, or in consultation with, a neurologist; and
- Patient is not receiving Uplizna in combination with any of the following:
  - Disease modifying therapies for the treatment of multiple sclerosis [e.g., Gilenya (fingolimod), Tecfidera (dimethyl fumarate), Ocrevus (ocrelizumab), etc.]
  - Complement inhibitors [e.g., Soliris (eculizumab)]
  - Anti-IL6 therapy [e.g., Actemra (tocilizumab)]
  - Anti-CD20 therapy (e.g., rituximab);

  and
- Initial authorization will be for no more than 6 months

Continuation of Therapy

- Documentation of positive clinical response; and
- Submission of medical records (e.g., chart notes, laboratory tests) to demonstrate a positive clinical response from baseline as demonstrated by at least both of the following:
  - Reduction in the number and/or severity of relapses or signs and symptoms of NMOSD
  - Maintenance, reduction, or discontinuation of dose(s) of any baseline immunosuppressive therapy (IST) prior to starting Uplizna (Note: Add on, dose escalation of IST, or additional rescue therapy from baseline to treat NMOSD or exacerbation of symptoms while on Uplizna therapy will be considered as treatment failure);

  and
- Uplizna is dosed according to the U.S. Food and Drug Administration (FDA) labeled dosing for NMOSD; and
- Prescribed by, or in consultation with, a neurologist; and
- Patient is not receiving Uplizna in combination with any of the following:
  - Disease modifying therapies for the treatment of multiple sclerosis [e.g., Gilenya (fingolimod), Tecfidera (dimethyl fumarate), Ocrevus (ocrelizumab), etc.]
  - Anti-IL6 therapy [e.g., Actemra (tocilizumab)]
  - Complement inhibitors [e.g., Soliris (eculizumab)]
  - Anti-CD20 therapy (e.g., rituximab);

  and
- Reauthorization will be for no more than 12 months

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

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

Diagnosis Code	Description
G36.0	Neuromyelitis optica [Devic]

Background

Uplizna (inebilizumab-cdon) is a CD19-directed humanized afucosylated IgG1 monoclonal antibody. The exact mechanism of action by which inebilizumab exerts its therapeutic effects in neuromyelitis optica spectrum disorder (NMOSD) is not known, but is presumed to involve binding to CD19, a cell surface antigen on pre-B and mature B lymphocytes. After cell surface binding to B lymphocytes, inebilizumab results in antibody-dependent cellular cytolysis.[5]

Clinical Evidence

Proven

Neuromyelitis Optica Spectrum Disorder (NMOSD)

Inebilizumab-cdon is indicated for the treatment of NMOSD.

Cree et al., evaluated the efficacy and safety of inebilizumab, in 230 patients with NMOSD over 44 months in a multicenter, double-blind, randomized placebo-controlled phase 2/3 study. One hundred seventy-four participants received inebilizumab and 56 participants received placebo. Eligible patients were adults (≥ 18 years old), an expanded disability status score (EDSS) of 8 or less, who required at least one rescue therapy treatment during the year prior to screening, or at least two attacks requiring rescue therapy in the 2 years before screening. Patients who were AQP4-IgG-seropositive and AQP4-IgG-seronegative were eligible; however, patients who were seronegative also needed to meet the criteria described by Wingerchuk and colleagues. The mean EDSS score was 4.0. The number of relapses in the two years prior to randomization was two or more in 83% of the patients. Participants were randomly allocated (3:1) to receive 300 mg intravenous inebilizumab or placebo on days 1 and 15, with a total dose of inebilizumab in the randomized controlled period of 600 mg. No further doses occurred after day 15 within the study period. All participants received oral corticosteroids to minimize the risk of an attack immediately following the first inebilizumab treatment. Primary endpoint was the time in days to the onset of an NMOSD attack, on or before day 197. Secondary endpoints included worsening of EDSS score from baseline, change from baseline in low-contrast visual acuity binocular score; cumulative total number of active MRI lesions, and number of NMOSD-related inpatient hospitalizations, longer than an overnight stay. The randomized controlled period was stopped prior to completion of enrollment, as there was a clear demonstration of efficacy: 12% of participants receiving inebilizumab had an attack, versus 39% of participants receiving placebo [RR 73%; HR 0.272 (95% CI 0.150-0.496); $p < 0.0001$]. In the anti-AQP4 antibody positive population, there was a 77.3% relative reduction (HR 0.227, $p < 0.0001$), whereas patients who were anti-AQP4 antibody negative had no evidence of benefit. 5 adverse events occurred in 72% of participants receiving inebilizumab and 73% of participants receiving placebo. Serious adverse events occurred in 5% of participants receiving inebilizumab and 9% of participants receiving placebo. The authors concluded that compared to placebo, inebilizumab reduced the risk of an NMOSD attack.[6]

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Uplizna is a CD19-directed cytolytic antibody indicated for the treatment of neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive.[5]

References

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Policy History/Revision Information

Date	Summary of Changes
08/01/2022	Application *Texas* • Replaced instruction to "refer to the state's Medicaid clinical policy" with "refer to the drug-specific criteria found within the *Texas Medicaid Provider Procedures Manual*" Supporting Information • Updated *References* section to reflect the most current information • Archived previous policy version CS2022D0091F

Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state, or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state, or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state, or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state, or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

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