

## Uplizna® (inebilizumab-cdon) (Intravenous)

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### I. Length of Authorization

Initial coverage will be provided for 6 months and may be renewed annually thereafter.

### II. Dosing Limits

#### A. Quantity Limit (max daily dose) [NDC Unit]:

- Loading Doses: 3 vials on days 1, 15
- Maintenance Dose: 3 vials every 6 months

#### B. Max Units (per dose and over time) [HCPCS Unit]:

- 300 billable units on days 1, 15 and then 300 billable units every 6 months thereafter

### III. Initial Approval Criteria <sup>1,2</sup>

Coverage is provided in the following conditions:

- Patient is at least 18 years of age; **AND**
- Patient has been evaluated and screened for the presence of hepatitis B virus (HBV) prior to initiating treatment and confirmed negative for active HBV; **AND**
- Patient has had baseline serum immunoglobulin measured prior to the start of therapy; **AND**
- Patient has not received intravenous immunoglobulin (IVIG) within 1 month prior to the start of therapy; **AND**
- Patient does not have an underlying immunodeficiency disorder (i.e., acquired/congenital primary immunodeficiency, HIV, etc.); **AND**

#### Universal Criteria <sup>1,2</sup>

- Patient has been evaluated and screened for the presence of latent TB infection prior to initiating treatment and will receive ongoing monitoring for presence of TB during treatment; **AND**

- Patient does not have an active infection, including clinically important localized infections; **AND**
- Live or live-attenuated vaccinations will not be administered within the 4-weeks prior to the start of therapy and will not be administered concurrently while on therapy; **AND**
- Patient has not previously received, and will not concomitantly receive, therapy with any of the following:
  - Other drugs which can result in prolonged additive immunosuppression [i.e., alemtuzumab, natalizumab, cyclosporin, methotrexate, mitoxantrone, cyclophosphamide, tocilizumab, maintenance corticosteroids (*not including pre-medications or rescue therapy*), etc.]; **AND**
  - Other immunosuppressant procedures (i.e., total lymphoid irradiation, bone marrow transplant, T-cell vaccination therapy, etc.); **AND**
- Patient will not concomitantly receive therapy with any of the following:
  - Complement-inhibitors (i.e., eculizumab, ravulizumab); **AND**
  - Anti-CD20-directed antibody (i.e., rituximab); **AND**
  - IL-6 inhibitor (i.e., satralizumab, tocilizumab, sarilumab, etc.) therapies; **AND**

#### **Neuromyelitis Optica Spectrum Disorder (NMOSD) † Φ <sup>1,2,4</sup>**

- Patient has a confirmed diagnosis based on the following:
  - Patient was found to be seropositive for aquaporin-4 (AQP4) IgG antibodies; **AND**
  - Patient has at least one core clinical characteristic §; **AND**
  - Alternative diagnoses have been excluded (e.g., multiple sclerosis, sarcoidosis, cancer, chronic infection, etc.); **AND**
- Patient has a history of one or more relapses that required rescue therapy within the prior year OR two or more relapses that required rescue therapy within the prior 2 years; **AND**
- Patient has an Expanded Disability Status Score (EDSS) of ≤ 7.5 (i.e., inability to take more than a few steps; restricted to wheelchair and may need aid in transferring; can wheel self but cannot carry on in standard wheelchair for a full day and may require a motorized wheelchair)

#### **§ Core Clinical Characteristics of NMOSD <sup>4</sup>**

- 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

† FDA Approved Indication(s); ‡ Compendia recommended indication(s); Φ Orphan Drug

#### IV. Renewal Criteria <sup>1,2</sup>

Coverage may be renewed based upon the following criteria:

- Patient continues to meet universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: serious or life-threatening infusion related reactions, serious infections including progressive multifocal leukoencephalopathy (PML), hypogammaglobulinemia necessitating IVIG treatment or leading to recurrent infections, etc.; **AND**
- Disease response as indicated by stabilization/improvement in one or more of the following:
  - Neurologic symptoms as evidenced by a decrease in acute relapses, improvement in stability, or improvement in EDSS
  - Reduced hospitalizations
  - Reduction/discontinuation in plasma exchange treatments

#### V. Dosage/Administration <sup>1</sup>

Indication	Dose
Neuromyelitis Optica Spectrum Disorder (NMOSD)	Uplizna is administered as an intravenous infusion, as follows: <ul style="list-style-type: none"><li>• <u>Initial dose</u>: 300 mg IV infusion followed 2 weeks later by a second 300 mg IV infusion.</li><li>• <u>Subsequent doses</u> (<i>starting 6 months from the first infusion</i>): single 300 mg IV infusion every 6 months.</li></ul>
<p>– Uplizna must be diluted prior to administration. Prior to the start of the intravenous infusion, the prepared infusion solution should be at room temperature.</p> <p>– Administer Uplizna under the close supervision of an experienced healthcare professional with access to appropriate medical support to manage potential severe reactions such as serious infusion reactions.</p> <p>– Administer the prepared solution intravenously via an infusion pump at an increasing rate to completion, approximately 90 minutes, according to the schedule in the PI.</p> <p>– Administer through an intravenous line containing a sterile, low-protein binding 0.2 or 0.22 micron in-line filter.</p>	

#### VI. Billing Code/Availability Information

HCPCS Code:

- J1823 – Injection, inebilizumab-cdon, 1 mg; 1 billable unit = 1 mg

NDC:

- Uplizna 100 mg/10 mL single-dose vials for injection: 75987-0150-xx

## VII. References

1. Uplizna [package insert]. Dublin, Ireland; Horizon Therapeutics Ireland DAC; July 2021. Accessed September 2022.
2. Cree BAC, Bennett JL, Kim HJ, et al; N-MOMentum study investigators. Inebilizumab for the treatment of neuromyelitis optica spectrum disorder (N-MOMentum): a double-blind, randomised placebo-controlled phase 2/3 trial. *Lancet*. 2019 Oct 12;394(10206):1352-1363. doi: 10.1016/S0140-6736(19)31817-3. Epub 2019 Sep 5.
3. Trebst C, Jarius S, Berthele A, et al. Update on the diagnosis and treatment of neuromyelitis optica: recommendations of the Neuromyelitis Optica Study Group (NEMOS). *J Neurol* 2014; 261:1.
4. Wingerchuk DM, Banwell B, Bennett JL, et al. International consensus diagnostic criteria for neuromyelitis optica spectrum disorders. *Neurology*. 2015 Jul;85(2):177-89. Epub 2015 Jun 19.

### Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
G36.0	Neuromyelitis optica [Devic]

### Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD), Local Coverage Article (LCAs) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at:

<https://www.cms.gov/medicare-coverage-database/search.aspx>. Additional indications may be covered at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCA/LCD): N/A

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	Applicable State/US Territory	Contractor
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA, LLC
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA, LLC

### Medicare Part B Administrative Contractor (MAC) Jurisdictions

Jurisdiction	Applicable State/US Territory	Contractor
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC

## Nondiscrimination & Language Access Policy

Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. We do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

We will:

Provide free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact us at the phone number shown on the inside cover of this *contract*, your id card, or aspirushealthplan.com.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with:

Nondiscrimination Grievance Coordinator  
Aspirus Health Plan, Inc.  
PO Box 1062  
Minneapolis, MN 55440  
Phone: 1.866.631.5404 (TTY: 711)  
Fax: 763.847.4010  
Email: customerservice@aspirushealthplan.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Nondiscrimination Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Language Assistance Services

**Albanian:** KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1.866.631.5404 (TTY: 711).

**Arabic:** تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بن اعلى رقم الهاتف 1.866.631.5404 (رقم هاتف الصم والبك : 711)

**French:** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelezle 1.866.631.5404 (ATS : 711).

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.866.631.5404 (TTY: 711).

**Hindi:** \_यान द\_ : य\_द आप िहंदी बोलते ह\_ तो आपके िलए मु\_त म\_ भाषा सहायता सेवाएं उपल\_ध ह\_। 1.866.631.5404 (TTY: 711) पर कॉल कर\_।

**Hmong:** LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.866.631.5404 (TTY: 711).

**Korean:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.866.631.5404 (TTY: 711)번으로 전화해 주십시오.

**Polish:** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.866.631.5404 (TTY: 711).

**Russian:** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.866.631.5404 (телетайп: 711).

**Spanish:** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.866.631.5404 (TTY: 711).

**Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1.866.631.5404 (TTY: 711)

**Traditional Chinese:** 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1.866.631.5404 (TTY:711)。

**Vietnamese:** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.866.631.5404 (TTY: 711).

**Pennsylvania Dutch:** Wann du Deitsch (Pennsylvania German / Dutch) schwetzsch, kannscht du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.866.631.5404 (TTY: 711).

**Lao:** ໄປ່ດຊາຍ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1.866.631.5404 (TTY:711).