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Medical Policy Bulletin
Title:
Inebilizumab-cdon (Uplizna)
Policy #:
MA08.126b

The Company makes decisions on coverage based on the Centers for Medicare and Medicaid Services (CMS) regulations and guidance, benefit plan documents and contracts, and the member's medical history and condition. If CMS does not have a position addressing a service, the Company makes decisions based on Company Policy Bulletins. Benefits may vary based on contract, and individual member benefits must be verified. The Company determines medical necessity only if the benefit exists and no contract exclusions are applicable. Although the Medicare Advantage Policy Bulletin is consistent with Medicare's regulations and guidance, the Company's payment methodology may differ from Medicare.

When services can be administered in various settings, the Company reserves the right to reimburse only those services that are furnished in the most appropriate and cost-effective setting that is appropriate to the member's medical needs and condition. This decision is based on the member's current medical condition and any required monitoring or additional services that may coincide with the delivery of this service.

This Policy Bulletin document describes the status of CMS coverage, medical terminology, and/or benefit plan documents and contracts at the time the document was developed. This Policy Bulletin will be reviewed regularly and be updated as Medicare changes their regulations and guidance, scientific and medical literature becomes available, and/or the benefit plan documents and/or contracts are changed.

Policy

Coverage is subject to the terms, conditions, and limitations of the member's Evidence of Coverage.

MEDICALLY NECESSARY

INITIAL CRITERIA
Inebilizumab-cdon (Uplizna™) is considered medically necessary and, therefore, covered for the treatment of adult individuals with neuromyelitis optica spectrum disorder (NMOSD), when all of the following criteria are met, including dosing and frequency:

- The individual has a diagnosis of NMOSD.
- The individual is anti-aquaporin-4 (AQP4) antibody seropositive.
- The individual has a history of one or more relapses that required rescue therapy within the year or two or more relapses that required rescue therapy in the past two years.
- Dosing and frequency for inebilizumab-cdon (UpliznaTM):
    - Initial dose: 300 mg intravenous infusion followed two weeks later by a second 300 mg intravenous infusion
    - Subsequent doses (starting six months from the first infusion): single 300 mg intravenous infusion every six months

CONTINUATION CRITERIA
Inebilizumab-cdon (Uplizna™) is considered medically necessary for continued use in adult individuals with a diagnosis of NMOSD when the initial criteria are met AND there is documentation of a positive clinical response (e.g., reductions in relapse or reduction in new onset of symptoms).

EXPERIMENTAL/INVESTIGATIONAL

All other uses for inebilizumab-cdon (Uplizna™) are considered experimental/investigational and, therefore, not

covered unless the indication is supported as an accepted off-label use, as defined in the Company medical policy on off-label coverage for prescription drugs and biologics.

DOSING AND FREQUENCY REQUIREMENTS

The Company reserves the right to modify the Dosing and Frequency Requirements listed in this policy to ensure consistency with the most recently published recommendations for the use of inebilizumab-cdon (UpliznaTM). Changes to these guidelines are based on a consensus of information obtained from resources such as, but not limited to: the US Food and Drug Administration (FDA); Company-recognized authoritative pharmacology compendia; or published peer-reviewed clinical research. The professional provider must supply supporting documentation (i.e., published peer-reviewed literature) in order to request coverage for an amount of inebilizumab-cdon (UpliznaTM) outside of the Dosing and Frequency Requirements listed in this policy. For a list of Company-recognized pharmacology compendia, view our policy on off-label coverage for prescription drugs and biologics.

Accurate member information is necessary for the Company to approve the requested dose and frequency of this drug. If the member's dose, frequency, or regimen changes (based on factors such as changes in member weight or incomplete therapeutic response), the provider must submit those changes to the Company for a new approval based on those changes as part of the utilization management activities. The Company reserves the right to conduct post-payment review and audit procedures for any claims submitted for inebilizumab-cdon (Uplizna™).

REQUIRED DOCUMENTATION

The individual's medical record must reflect the medical necessity for the care provided. These medical records may include, but are not limited to: records from the professional provider's office, hospital, nursing home, home health agencies, therapies, and test reports.

The Company may conduct reviews and audits of services to our members, regardless of the participation status of the provider. All documentation is to be available to the Company upon request. Failure to produce the requested information may result in a denial for the drug.

Guidelines

DRUG INFORMATION

In accordance with US Food and Drug Administration (FDA) prescribing information, inebilizumab-cdon (Uplizna™) is administered as an intravenous infusion titrated to completion, approximately 90 minutes. The recommended initial dose: 300 mg intravenous infusion followed 2 weeks later by a second 300 mg intravenous infusion. Subsequent doses (starting 6 months from the first infusion): single 300 mg intravenous infusion every 6 months.

BENEFIT APPLICATION

Subject to the terms and conditions of the applicable Evidence of Coverage, inebilizumab-cdon (Uplizna™) is covered under the medical benefits of the Company's Medicare Advantage products when the medical necessity criteria listed in this medical policy are met.

US FOOD AND DRUG ADMINISTRATION (FDA) STATUS

Inebilizumab-cdon (Uplizna™) injection for intravenous use, was approved by the FDA on June 11, 2020 for the treatment of neuromyelitis optica spectrum disorder (NMOSD) in adult individuals who are anti-aquaporin-4 (AQP4) antibody positive.

PEDIATRIC USE

The safety and effectiveness of inebilizumab-cdon (Uplizna™) for the treatment of neuromyelitis optica spectrum disorder (NMOSD) in pediatric individuals have not been established.

Description

Inebilizumab-cdon (Uplizna™) is a CD19-directed humanized afucosylated IgG1 monoclonal antibody produced by recombinant DNA technology in Chinese hamster ovary (CHO) cell suspension culture. The molecular weight is approximately 149 kDa. Inebilizumab-cdon (Uplizna™) depletes the B cells in the body that produce autoantibodies against AQP4. This reduces the frequency of attacks and the severity of symptoms. Inebilizumab-cdon (Uplizna™) was approved by the US Food and Drug Administration (FDA) for neuromyelitis optica spectrum disorder (NMOSD) on June 11, 2020.

NEUROMYELITIS OPTICA SPECTRUM DISORDER (NMOSD)

Neuromyelitis optica spectrum disorder (NMOSD) is a relapsing, autoimmune, inflammatory disorder that typically affects the optic nerves and spinal cord. At least two thirds of cases are associated with aquaporin-4 antibodies (AQP4-IgG) and complement-mediated damage to the central nervous system.

The safety and efficacy of inebilizumab-cdon (Uplizna™) for the treatment of individuals with AQP4-IgG–positive neuromyelitis optica were evaluated in a Study 1, in which 161 individuals were exposed to inebilizumab-cdon (Uplizna™) at the recommended dosage regimen during the randomized, controlled treatment period, during which 52 individuals received placebo. Subsequently, 198 individuals were exposed to inebilizumab-cdon (Uplizna™) during an open-label treatment period. Two-hundred and eight individuals in the randomized and open-label treatment periods had a total of 324 person-years of exposure to inebilizumab-cdon (Uplizna™), including 165 individuals with exposure for at least 6 months and 128 with exposure for one year or more. The Study 1 included AQP4-IgG antibody-positive and AQP4-IgG antibody- negative individuals. During the 197-day study, the risk of an NMOSD relapse in the 161 anti-AQP4 antibody- positive individuals who were treated with inebilizumab-cdon (Uplizna™) was reduced by 77% when compared to the placebo treatment group. There was no evidence of a benefit in individuals who were anti-AQP4 antibody--negative. The most common adverse reactions in the NMOSD clinical trial were urinary tract infection, headache, joint pain (arthralgia), nausea, and back pain.

OFF-LABEL INDICATION

There may be additional indications contained in the Policy section of this document due to evaluation of criteria highlighted in the Company's off-label policy, and/or review of clinical guidelines issued by leading professional organizations and government entities.

References

ClinicalTrials.gov. A Double-masked, Placebo-controlled Study With Open Label Period to Evaluate MEDI-551 in Neuromyelitis Optica and Neuromyelitis Optica Spectrum Disorders. ClinicalTrials.gov Identifier: NCT02200770. First Posted: July 25, 2014; Last Update Posted: June 11, 2020. Available at: https://clinicaltrials.gov/ct2/show/NCT02200770. Accessed July 17, 2020.

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17, 2020.

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US Food and Drug Administration (FDA). Center for Drug Evaluation and Research. Inebilizumab-cdon (Uplizna™). prescribing information and approval letter [FDA Web site]. updated 06/11/2020. Available at: https://www.accessdata.fda.gov/scripts/cder/daf/. Accessed July 17, 2020.

Coding

Inclusion of a code in this table does not imply reimbursement. Eligibility, benefits, limitations, exclusions, precertification/referral requirements, provider contracts, and Company policies apply.

The codes listed below are updated on a regular basis, in accordance with nationally accepted coding guidelines. Therefore, this policy applies to any and all future applicable coding changes, revisions, or updates.

In order to ensure optimal reimbursement, all health care services, devices, and pharmaceuticals should be reported using the billing codes and modifiers that most accurately represent the services rendered, unless otherwise directed by the Company.

The Coding Table lists any CPT, ICD-10, and HCPCS billing codes related only to the specific policy in which they appear.

CPT Procedure Code Number(s)
N/A

ICD - 10 Procedure Code Number(s)
N/A

ICD - 10 Diagnosis Code Number(s)
G36.0 Neuromyelitis optica [Devic]

HCPCS Level II Code Number(s)
THE FOLLOWING CODES ARE USED TO REPRESENT
Inebilizumab-cdon (Uplizna™)

J1823 Injection, inebilizumab-cdon, 1 mg

Revenue Code Number(s)
N/A

Policy History

Revision From MA08.126b

05/07/2024	This policy has been reissued in accordance with the Company's annual review process.
09/05/2023	This policy has been reissued in accordance with the Company's annual review process.
05/04/2022	This policy has been reissued in accordance with the Company's annual review process.
08/09/2021	This version of the policy will become effective 08/09/2021.

	The criteria section has been updated to include dosing and frequency for inebilizumab-cdon (UpliznaTM).

Revisions From MA08.126a:

01/01/2021	This policy has been identified for the HCPCS code update, effective 01/01/2021. The following NOC code has been **removed** from this policy and is replaced by the following HCPCS code: **REMOVED:** C9399 Unclassified drugs or biologicals J3590 Unclassified biologics **REPLACED WITH:** **J1823 Injection, inebilizumab-cdon, 1 mg**

Revisions From MA08.126:

09/14/2020	This version of the policy will become effective 09/14/2020. This new policy has been developed to communicate the Company's coverage criteria for Inebilizumab-cdon (Uplizna™).

Version Effective Date:
08/09/2021
Version Issued Date:
08/09/2021
Version Reissued Date:
05/07/2024