Clinical Policy Title:	inebilizumab-cdon
Policy Number:	RxA.648
Drug(s) Applied:	Uplizna®
Original Policy Date:	09/14/2020
Last Review Date:	06/10/2021
Line of Business Policy Applies to:	All lines of business

Background

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.

Neuromyelitis optica spectrum disorder (NMOSD) attacks the optic nerve, spinal cord and brain stem, often leading to irreversible blindness and paralysis—and in the most severe cases—this can occur with just one attack. Patients may also experience loss of sensation, bladder and bowel dysfunction, nerve pain and respiratory failure, with each subsequent attack leading to further damage and disability. As of 2016, there were approximately 10,000 people in the U.S. suffering from NMOSD.

Dosing Information

Drug Name	Indication	Dosing Regimen	Maximum Dose
inebilizumab-cdon (Uplizna®)	Neuromyelitis optica spectrum disorder (NMOSD), Anti-aquaporin-4 (AQP4) antibody positive.	Initial dose: 300 mg IV followed by second 300 mg IV dose after 2 weeks . Subsequent doses: 300 mg IV every 6 months starting 6 months from the first infusion.	300 mg IV per dose

Dosage Forms

Injection: 100 mg/10 mL (10 mg/mL) solution in a single-dose vial

Clinical Policy

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria. The provision of provider samples does not guarantee coverage under the terms of the pharmacy benefit administered by RxAdvance. All criteria for initial approval must be met in order to obtain coverage.

I. Initial Approval Criteria

A. Neuromyelitis Optica Spectrum Disorder (must meet all):

1. Diagnosis of NOSD confirmed by seropositive test for aquaporin-4 (AQP4) IgG antibodies;
2. Age 18 years or older;
3. Prescribed by or in consultation with a neurologist;
4. Failure of rituximab at up to maximally indicated doses, unless contraindicated or clinically significant

adverse effects are experienced; na® (See Appendix D);
5. Baseline expanded disability status score (EDSS) score of ≤ 7.5;
6. Member had a history of one or more relapses that required rescue therapy within the year prior to screening, or 2 or more relapses that required rescue therapy in 2 years prior to screening;
7. Dose does not exceed 300 mg IV per dose for initial and maintenance doses.

Approval Duration
Commercial: 7 months (includes two loading doses and one dose 6 months later)
Medicaid: 7 months (includes two loading doses and one dose 6 months later)

II. Continued Therapy Approval

A. Neuromyelitis Optica Spectrum Disorder (must meet all):

1. Member is currently receiving medication that has been authorized by RxAdvance or the member has met initial approval criteria listed in this policy;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 300 mg IV per dose.

Approval Duration
Commercial: 12 months
Medicaid: 12 months

III. Appendices

APPENDIX A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
NOSD: Neuromyelitis Optica Spectrum Disorder
EDSS: expanded disability status score

APPENDIX B: Therapeutic Alternatives
Below are suggested therapeutic alternatives based on clinical guidance. Please check drug formulary for preferred agents and utilization management requirements.

Drug Name	Dosing Regimen	Dose Limit/Maximum Dose
Soliris® (teriflunomide)	900 mg IV infusion every 7 days for the first 4 weeks, followed by a single dose of 1,200 mg IV infusion given 7 days after the fourth dose, and then 1,200 mg IV infusion every 14 days	1,200 mg IV per dose
Enspryng™ (satralizumab-mwge)	Loading Dose: 120 mg subcutaneously on weeks 0, 2 and 4 Maintenance Dose: 120 mg subcutaneously every 4 weeks	120mg every 4 weeks

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

APPENDIX C: Contraindications/Boxed Warnings

- Contraindication(s):
  - A history of a life-threatening infusion reaction to Uplizna®
  - Active hepatitis B infection

- Active or untreated latent tuberculosis

- Boxed Warning(s):
  - None.

APPENDIX D: General Information

- Treatment of Neuromyelitis Optica Spectrum Disorder: Acute, Preventive, and Symptomatic.
- Guidelines have not been updated since approval of eculizumab and inebilizumab-cdon.
- Examples of positive response to therapy include: Stabilization or reduction in EDSS total score. EDSS ranges from 0 (no disability) to 10 (death).
- Assessments prior to first dose of Uplinza®:
  - Hepatitis B Virus Screening;
  - Serum Immunoglobulins;
  - Tuberculosis Screening;
  - Vaccinations: Because vaccination with live-attenuated or live vaccines is not recommended during treatment and after discontinuation until B-cell repletion, administer all immunizations according to immunization guidelines at least 4 weeks prior to initiation of Uplinza® for live or liveattenuated vaccines.
- Expanded Disability Status Score (EDSS) ≤7.5 indicates the inability to take more than a few steps. Patient is restricted to wheelchair and may need help getting in and out. May need motorised wheelchair or can wheel self but cannot carry on in standard wheelchair for a full day.

References

1. Uplizna® (inebilizumab-cdon) [prescribing information]. Gaithersburg, MD: Viela Bio; December 2020. Available at: https://www.uplizna.com/ . Accessed on April 20,2021.
2. Cree BAC, Bennett JL, Kim HJ, et al. Inebilizumab for the treatment of neuromyelitis optica spectrum disorder (N-MOmentum): a double-blind, randomised placebo-controlled phase 2/3 trial. Lancet 2019; 394:1352.
3. Kessler RA, et al. Treatment of Neuromyelitis Optica Spectrum Disorder: Acute, Preventive, and Symptomatic. Curr Treat Options Neurol. 2016;18(1):2. doi: 10.1007/s11940-015-0387-9
4. Viela Bio Announces U.S. FDA Approval of Uplizna™ (inebilizumab-cdon) for the Treatment of Neuromyelitis Optica Spectrum Disorder (NMOSD). GlobeNewsWire. 2020. Available at https://www.globenewswire.com/news-release

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	08/11/2020	09/14/2020
Policy was reviewed: 1. Clinical policy tittle was updated. 2. Appendix B verbiage added "Below are suggested...". 3. Initial approval criteria was updated: added I.A.3 and changed EDSS score from 7 to 7.5 as per the PI of criteria I.A.4. 4. Appendix D updated. 5. Updated initial approval criteria with additional criteria based on	04/20/2021	06/10/2021

clinical trial information 6. Updated therapeutic alternatives to include Enspryng 7. References reviewed and updated.		