Uplizna (inebilizumab-cdon)
Effective 03/01/2021

Plan	☒ MassHealth ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☒ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☒ Medical Benefit (NLX)		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy when obtained through the pharmacy benefit.		
Contact Information	**Specialty Medications**		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions	N/A		

Overview
Uplizna is indicated for the treatment of neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive.

Coverage Guidelines
Authorization may be reviewed on a case by case basis for members new to AllWays Health Partners who are currently receiving treatment with the Uplizna excluding when the product is obtained as samples or via manufacturer's patient assistance programs.

OR

Authorization may be granted for members when ALL the following criteria are met, and documentation is provided:

1. Anti-aquaporin-4 (AQPR) antibody positive
2. Member exhibits one of the following core clinical characteristics of NMOSD:
   a. Optic neuritis
   b. Acute myelitis
   c. Area postrema syndrome (episode of otherwise unexplained hiccups or nausea and vomiting)
   d. Acute brainstem syndrome
   e. Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic magnetic resonance imaging (MRI) lesions
   f. Symptomatic cerebral syndrome with NMOSD-typical brain lesions
3. The member will not receive the requested drug concomitantly with other biologics for the treatment of NMOSD.

Continuation of Therapy

Reauthorization requires physician documentation of continuation of therapy and positive response to therapy (e.g., reduction in number of relapses) and the member will not receive the requested drug concomitantly with other biologics for the treatment of NMOSD.

Limitations

1. Initial approvals and reauthorizations will be for 12 months.
2. The following quantity limits apply:

Uplizna 100mg/10mL	Loading dose: 60mL for 1 month
	Maintenance dose: 60mL per 12 months

References

1. Uplizna [package insert]. Baithersburg, MD: Viela Bio, Inc.; June 2020.
2. Wingerchuk DM, Banwell B, Bennett JL, et al. International consensus diagnostic criteria for neuromyelitis optica spectrum disorders. Neurology. 2015; 85:177-189.

Review History

01/23/2021 – Created and Reviewed Jan P&T. Effective 3/1/21.

Disclaimer

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