Drug Coverage Policy

Effective Date.....12/1/2025
Coverage Policy Number.....IP0587
Policy Title.....Veopoz

Complement Inhibitors – Veopoz

- Veopoz® (pozelimab-bbfg intravenous infusion and subcutaneous injection – Regeneron)

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

OVERVIEW

Veopoz, a complement inhibitor, is indicated for the treatment of CD55-deficient protein-losing enteropathy, also known as CHAPLE disease, in adult and pediatric patients ≥ 1 year of age.[1]

Disease Overview
CHAPLE (which stands for Complement Hyperactivation, Angiopathic thrombosis, and Protein-Losing Enteropathy) disease is an ultra-rare inherited immune disease that causes the complement system to become overactive.[2-4] It is caused by biallelic loss-of-function variants in the CD55 gene, which leads to loss of protein expression and can result in the complement system attacking the body's own cells. There are fewer than 100 patients diagnosed worldwide with CHAPLE disease; it is estimated to impact around 10 patients in the US. Symptoms can include abdominal pain, nausea, vomiting, diarrhea, loss of appetite, weight loss, impaired growth, and edema. Severe thrombotic vascular occlusions (blockage of blood vessels) can also occur among patients with CHAPLE disease, which can be life-threatening. The condition mainly impacts children, including infants, and is associated with morbidity and a higher risk of mortality.

Dosing Information
Veopoz is administered by a healthcare provider.[1] On Day 1, give a single 30 mg/kg loading dose by intravenous infusion. Day 8 and thereafter, the maintenance dose is 10 mg/kg as a subcutaneous injection once weekly. The maintenance dosage may be increased to 12 mg/kg once weekly if there is inadequate clinical response after at least three weekly doses (starting from Week 4). The maximum maintenance dosage is 800 mg once weekly. Doses exceeding 400 mg require two injections.

Safety
Veopoz has a Boxed Warning regarding serious meningococcal infections.[1] Life-threatening and fatal meningococcal infections have occurred in patients treated with complement inhibitors. Complete or update meningococcal vaccination at least 2 weeks before administering the first dose of Veopoz, unless the risks of delaying therapy outweigh the risks of developing meningococcal infection. Follow the most current Advisory Committee on Immunization Practices (ACIP) recommendations for meningococcal vaccination in patients receiving a complement inhibitor. Also, patients treated with Veopoz may be at increased risk for invasive disease caused by *Neisseria meningitidis*, even if they develop antibodies following vaccination. Patients treated with Veopoz may be at increased risk of developing serious infections due to *Streptococcus pneumoniae* and *Haemophilus influenzae* type b infections; administer related vaccinations according to ACIP guidelines.

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POLICY STATEMENT
Prior Authorization is required for benefit coverage of Veopoz. Approval is recommended for those who meet the **Criteria** and **Dosing** for the listed indication. Extended approvals are allowed if the patient continues to meet the Criteria and Dosing. Requests for doses outside of the established dosing documented in this policy will be considered on a case-by-case basis by a clinician (i.e., Medical Director or Pharmacist). All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with Veopoz as well as the monitoring required for adverse events and long-term efficacy, approval requires Veopoz to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Documentation: Documentation is required where noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information.

Veopoz is considered medically necessary when the following are met:

FDA-Approved Indication

1. **CD55-Deficient Protein-Losing Enteropathy (CHAPLE Disease [Complement Hyperactivation, Angiopathic thrombosis, and Protein-Losing Enteropathy]).** Approve for the duration noted below if the patient meets ONE of the following (A or B):
   A) Initial Therapy. Approve for 3 months if the patient meets ALL of the following (i, ii, iii, and iv):
   i. Patient is ≥ 1 year of age; AND
   ii. Patient has had a genetic test confirming the diagnosis of CHAPLE disease with a biallelic *CD55* loss-of-function pathogenic variant **[documentation required]**; AND
   iii. Patient meets BOTH of the following (a and b):
   a) Patient has a serum albumin level ≤ 3.2 g/dL **[documentation required]**; AND
   b) According to the prescribing physician, the patient has active disease and is experiencing one or more signs or symptoms within the last 6 months; AND
   Note: Examples of signs and symptoms include abdominal pain, diarrhea, vomiting, peripheral edema, or facial edema.
   iv. Medication is prescribed by a physician with expertise in managing CHAPLE disease; OR

   B) Patient Currently Receiving Veopoz. Approve for 1 year if the patient meets ALL of the following (i, ii, iii, and iv):
   i. Patient is ≥ 1 year of age; AND
   ii. Patient has had a genetic test confirming the diagnosis of CHAPLE disease with a biallelic CD55 loss-of-function pathogenic variant **[documentation required]**; AND
   iii. Medication is prescribed by a physician with expertise in managing CHAPLE disease; AND
   iv. Patient had experienced a response to therapy **[documentation required]**.
   Note: Examples of a response to therapy include increased serum albumin levels, maintenance of serum albumin levels within a normal range, a reduction in albumin transfusions, increases in or maintenance of protein and/or immunoglobulin levels, improvement in clinical outcomes after receipt of therapy (e.g., decreases in the frequency of problematic abdominal pain, bowel movement frequency, facial edema severity, and peripheral edema severity), reduced frequency in hospitalizations, increase in growth percentiles (e.g., body weight-for age and/or stature-for-age percentiles), and/or reduced use of corticosteroids.

   Dosing. Approve a single 30 mg/kg loading dose by intravenous infusion on Day 1, followed by up to 12 mg/kg subcutaneously once weekly (up to a maximum of 800 mg).

Conditions Not Covered

Veopoz for any other use is considered not medically necessary, including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. **Concomitant Use with Other Complement Inhibitors.** In the pivotal study, use of other complement inhibitors was prohibited.

Coding Information

1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

HCPCS Codes	Description
J9376	Injection, pozelimab-bbfg, 1 mg

References

1. Veopoz® intravenous infusion and subcutaneous injection [prescribing information]. Tarrytown, NY: Regeneron; March 2024.
2. Ozen A, Chongsrisawat V, Sefer AP, et al, for the Pozelimab CHAPLE working group. Evaluating the efficacy and safety of pozelimab in patients with CD55 deficiency with hyperactivation of complement, angiopathic thrombosis, and protein-losing enteropathy: an open-label, Phase 2 and 3 study. *Lancet*. 2024;403(10427):645-656.
3. Hoy SM. Pozelimab: first approval. *Drugs*. 2023;83(16):1551-1557.
4. Can S, Altunbas MY, Ozen A. Pharmacotherapy for CD55 deficiency with CHAPLE disease: how close are we to a cure? *Expert Opin Pharmacother*. 2024;25(11):1421-1426.

Revision Details

Type of Revision	Summary of Changes	Date
Selected Revision	**CD55-Deficient Protein-Losing Enteropathy (CHAPLE Disease [Complement Hyperactivation, Angiopathic thrombosis, and Protein-Losing Enteropathy]):** Removed the statement "Does not have active meningococcal infection". **Updated Coding:** **Added** J9376 **Removed** C9399, J3490, J3590	11/15/2024
Annual Revision	**Updated** policy title **from** "Pozelimab-bbfj" **to** "Complement Inhibitors – Veopoz." **CD55-Deficient Protein-Losing Enteropathy (CHAPLE Disease [Complement Hyperactivation, Angiopathic thrombosis, and Protein-Losing Enteropathy]):** The following requirements were removed that the patient has received or is in compliance with updated meningococcal vaccinations according to the most current Advisory Committee on Immunization Practices recommendations and that the patient has received or is in compliance with updated vaccinations for the prevention of Streptococcus pneumonia and Haemophilus influenza type b	12/1/2025

	infections according to the most current Advisory Committee on Immunization Practices guidelines. For initial therapy and for a patient currently receiving Veopoz, the phrase "pathogenic variant" replaced "mutation". **Added [documentation required]** to the following criterion "Patient has a serum albumin level ≤ 3.2 g/dL." **Added** criteria for "Patient Currently Receiving Veopoz."	

The policy effective date is in force until updated or retired.