pozelimab-bbfg (Veopoz)

Commercial Medical Benefit Drug Policy

Place of Service

Home Infusion
Infusion Center Administration
Office Administration
Outpatient Facility Infusion Administration

Drug Details

USP Category: GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT
Mechanism of Action: Complement C5 inhibitor
HCPCS:
J9376:Injection, pozelimab-bbfg, 1 mg
How Supplied:
400 mg/2 mL (200 mg/mL) in a single-dose vial

Condition(s) listed in policy *(see coverage criteria for details)*

- CHAPLE disease

Any condition not listed in this policy requires a review to confirm it is medically necessary. For conditions that have not been approved for intended use by the Food and Drug Administration (i.e., off-label use), the criteria outlined in the Health and Safety Code section 1367.21 must be met.

Special Instructions and Pertinent Information

Provider must submit documentation (such as office chart notes, lab results or other clinical information) to ensure the member has met all medical necessity requirements.

The member's specific benefit may impact drug coverage. Other utilization management processes, and/or legal restrictions may take precedence over the application of this clinical criteria.

For billing purposes, drugs must be submitted with the drug's assigned HCPCS code (as listed in the drug policy) and the corresponding NDC (national drug code). An unlisted, unspecified, or miscellaneous code should not be used if there is a specific code assigned to the drug.

Coverage Criteria
The following condition(s) require Prior Authorization/Preservice.

CHAPLE disease
Meets medical necessity if all the following are met:
1. Patient is 1 year of age or older
2. Confirmation of biallelic CD55 loss-of-function mutation detected by genotype analysis

Covered Doses:
Day 1 (loading dose): 30 mg/kg given by intravenous infusion
Day 8 and thereafter (maintenance dosage): 10 mg/kg given 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 3 weekly doses (i.e., starting from Week 4). The maximum maintenance dosage is 800 mg once weekly.

Coverage Period:
Yearly, based on continued response to therapy

ICD-10:
D84.1, K90.49

References

1. AHFS®. Available by subscription at http://www.lexi.com
2. DrugDex®. Available by subscription at http://www.micromedexsolutions.com/home/dispatch
3. Veopoz (pozelimab-bbfg) [prescribing information]. Tarrytown, NY: Regeneron Pharmaceuticals Inc; March 2024.

Review History

Date of Last Annual Review: 4Q2025
Changes from previous policy version:

- No clinical change following annual review.

Blue Shield of California Medication Policy to Determine Medical Necessity
Reviewed by P&T Committee