

Inebilizumab-cdon (Uplizna™)

Goal(s):

- Restrict use to OHP funded conditions and according to OHP guidelines for use.
- Promote use that is consistent with national clinical practice guidelines and medical evidence.

Length of Authorization:

Up to 12 months

Requires PA:

- Uplizna™ (Inebilizumab-cdon) (pharmacy and physician administered claims)

Covered Alternatives:

- Current PMPDP preferred drug list per OAR 410-121-0030 at www.orpdl.org
- Searchable site for Oregon FFS Drug Class listed at www.orpdl.org/drugs/

Approval Criteria		
1. What diagnosis is being treated?	Record ICD10 code.	
2. Is the diagnosis funded by OHP?	Yes: Go to #6	No: Pass to RPh. Deny; not funded by the OHP.
3. Is this request for continuation of therapy?	Yes: Go to Renewal Criteria	No: Go to # 4
4. Is the request for Neuromyelitis Optica Spectrum Disorder (NMOSD) in an adult who is anti-aquaporin-4 (AQP4) antibody positive?	Yes: Go to #5	No: Pass to RPh. Deny; medical appropriateness
5. Has the patient been screened for Hepatitis B and tuberculosis infection?	Yes: Go to #6	No: Pass to RPh. Deny; medical appropriateness
6. Does the patient have active Hepatitis B or untreated latent tuberculosis?	Yes: Pass to RPh. Deny; medical appropriateness	No: Approve for 12 months

Renewal Criteria		
<p>1. Is there objective documentation of treatment benefit from baseline?</p> <p>Appropriate measures will vary by indication (e.g., hemoglobin stabilization, decreased transfusions, symptom improvement, functional improvement, etc.).</p>	<p>Yes: Approve for 12 months</p> <p>Document baseline assessment and physician attestation received.</p>	<p>No: Pass to RPh. Deny; medical appropriateness</p>