

#### Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Veopoz under the patient's prescription drug benefit.

#### **Description:**

#### FDA-Approved Indication

Veopoz is indicated for the treatment of adult and pediatric patients 1 year of age and older with CD55-deficient protein-losing enteropathy (PLE), also known as CHAPLE disease.

All other indications are considered experimental/investigational and not medically necessary.

#### **Applicable Drug List:**

Veopoz

## **Policy/Guideline:**

#### Documentation

Submission of the following information is necessary to initiate the prior authorization review:

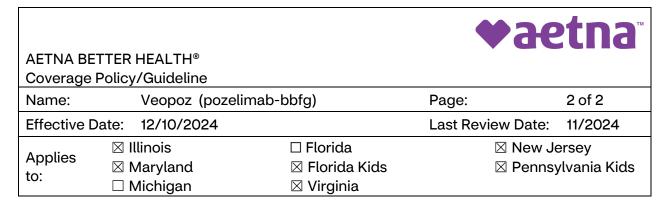
- A. For initial requests: chart notes, medical records and genetic test results documenting:
  - 1. Confirmed biallelic CD55 loss-of-function mutation
  - 2. Hypoalbuminemia (serum albumin concentration of <3.2 g/dL)
  - 3. Signs and symptoms of CD-55 PLE (e.g., abdominal pain, diarrhea, peripheral edema, or facial edema)
- B. For continuation requests: Chart notes or medical record documentation supporting positive clinical response.

## **Criteria for Initial Approval:**

## CD55-deficient protein-losing enteropathy (PLE)

Authorization may be granted for treatment of CD55-deficient protein-losing enteropathy (PLE) when ALL the following criteria are met:

- A. The member has a confirmed biallelic CD55 loss-of-function mutation detected by genotype analysis
- B. The member has hypoalbuminemia (serum albumin concentration of  $\leq$  3.2 g/dL)



- C. The member has one or more of the following signs and symptoms of CD-55 PLE within the past 6 months:
  - 1. Abdominal pain
  - 2. Diarrhea
  - 3. Peripheral edema
  - 4. Facial edema

# **Continuation of Therapy**

# CD55-deficient protein-losing enteropathy (PLE)

Authorization may be granted for continued treatment in members requesting reauthorization when ALL the following criteria are met:

- A. There is no evidence of unacceptable toxicity or disease progression while on the current regimen
- B. Member demonstrates a positive response to therapy (e.g., normalization of serum albumin, improvement in signs and symptoms of disease, and/or decrease in number of hospitalizations and infections)

# Approval Duration and Quantity Restrictions:

Initial Approval: 6 months Renewal Approval: 12 months

Quantity Level Limit: Reference Formulary for drug specific quantity level limits

## **References:**

1. Veopoz [package insert]. Tarrytown, NY: Regeneron Pharmaceuticals, Inc.; March 2024.