AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Veopoz (pozelimab-bbfg)	Page:	1 of 2
Effective Date:	12/10/2024	Last Review Date:	11/2024

Applies to:	☒ Illinois	☐ Florida	☒ New Jersey
	☒ Maryland	☒ Florida Kids	☒ Pennsylvania Kids
	☐ Michigan	☒ Virginia	

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 ≤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.