Uplizna (inebilizumab) is a non-preferred product and will only be considered for coverage under the medical benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

**NEUROMYELITIS OPTICA SPECTRUM DISORDER (NMOSD)**

For initial authorization:
1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a neurologist; AND
3. Member has a diagnosis of NMOSD and is seropositive for aquaporin-4 (AQP4) IgG antibodies (documentation required); AND
4. Member has had 1 or more relapses within the past year; AND
5. Member has tried and failed at least one of the following for 6 months or longer: azathioprine, mycophenolate, rituximab,2,4,5 (requires prior auth); AND
6. Member has tried and failed Enspryng (requires prior auth) for at least 6 months or has contraindication; AND
7. Member has tested negative for hepatitis B and tuberculosis within the past year.
8. **Dosage allowed:** 300mg IV infusion on days 1 and 15 followed by 300mg IV infusion every 6 months.

**If member meets all the requirements listed above, the medication will be approved for 6 months.**

For reauthorization:
1. Chart notes must document disease stabilization, symptom improvement, and/or reduced frequency of relapses.

**If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.**

CareSource considers Uplizna (inebilizumab) not medically necessary for the treatment of diseases that are not listed in this document.
References:


Effective date: 04/01/2021
Revised date: 10/02/2020