JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Pharmacy Public** **Medical Management Drug Policies**	*Policy Number*	MMDP116
		Effective Date	07/17/2024
		Approval Date	07/17/2024
	Subject **Veopoz**	*Supersedes Date*	N/A
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This document applies to the following Participating Organizations:

US Family Health Plan

Keywords: Veopoz

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I. POLICY

A. Veopoz (pozelimab-bbfg) will require prior authorization for medical benefit coverage to ensure appropriate use. The process for initiating a prior authorization request can be found in policy PHARM 20.

II. POLICY CRITERIA

A. Veopoz may be approved for patients who meet the following:
   1. Documentation has been submitted showing all the following:
      a. Diagnosis of CD55-deficient protein-losing enteropathy (PLE)
      b. Patient has a confirmed biallelic CD55 loss-of-function mutation detected by genotype analysis
      c. Patient has hypoalbuminemia (serum albumin concentration of ≤3.2 g/dL)
      d. Patient has had one or more of the following signs and symptoms of CD-55 PLE within the past 6 months:
         I. Abdominal pain
         II. Diarrhea
         III. Peripheral edema
         IV. Facial edema

III. AUTHORIZATION PERIOD/LIMITATIONS

A. Initial approval will be limited to 6 months of therapy
B. Continuation of therapy may be approved in 12-month intervals with documentation showing the patient has not experienced unacceptable toxicity or disease progression while on therapy, and has had a beneficial response to therapy, evidenced by any of the following:
   1. normalization of serum albumin
   2. improvement in signs and symptoms of disease
   3. decrease in number of hospitalizations and infections

IV. EXCLUSIONS

A. Veopoz will not be covered for the following:

1. Any indications or uses that are not FDA-approved, or guideline-supported

V. RECOMMENDED DOSE

Please refer to the FDA-approved prescribing information, or clinical guidelines, for indication-specific dosing details.

VI. CODES

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Note: The following CPT/HCPCS codes are included below for informational purposes. Inclusion or exclusion of a CPT/HCPCS code(s) below does not signify or imply member coverage or provider reimbursement. The member's specific benefit plan determines coverage.

Medication	HCPCS/CPT Code
Injection, pozelimab-bbfg, 1 mg	J9376

VII. REFERENCES

1. Veopoz [prescribing information]. Tarrytown, NY: Regeneron Pharmaceuticals, Inc.; August 2023.

VIII. APPROVALS

Signature on file at JHHP

DATE OF REVISION	SUMMARY OF CHANGE
07/17/2024	Policy creation

Review Date: 07/17/2024

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