Reference number(s)
6134-A

Specialty Guideline Management
Veopoz

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Veopoz	pozelimab-bbfg

Indications

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-approved Indications

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.

Documentation

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

- For initial requests: chart notes, medical records and genetic test results documenting:
  - Confirmed biallelic CD55 loss-of-function mutation
  - Hypoalbuminemia (serum albumin concentration of ≤3.2 g/dL)

    - Signs and symptoms of CD-55 PLE (e.g., abdominal pain, diarrhea, peripheral edema, or facial edema)
- For continuation requests: Chart notes or medical record documentation supporting positive clinical response.

Coverage Criteria

CD55-Deficient Protein-Losing Enteropathy (PLE)

Authorization of 6 months may be granted for treatment of CD55-deficient protein-losing enteropathy (PLE) when all of the following criteria are met:

- The member has a confirmed biallelic CD55 loss-of-function mutation detected by genotype analysis
- The member has hypoalbuminemia (serum albumin concentration of ≤3.2 g/dL)
- The member has one or more of the following signs and symptoms of CD-55 PLE within the past 6 months:
    - Abdominal pain
    - Diarrhea
    - Peripheral edema
    - Facial edema

Continuation of Therapy

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization when there is no evidence of unacceptable toxicity or disease progression while on the current regimen and 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)

References

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