CARECONTINUUM™

UTILIZATION MANAGEMENT MEDICAL POLICY

POLICY: Complement Inhibitors – Veopoz Utilization Management Medical Policy
- Veopoz® (pozelimab-bbfg intravenous infusion and subcutaneous injection – Regeneron)

REVIEW DATE: 09/03/2025

OVERVIEW
Veopoz, a complement inhibitor, is indicated for the treatment of CD55-deficient protein-losing enteropathy, also known as CHAPLE disease, in adult and pediatric patients ≥ 1 year of age.[1]

Disease Overview
CHAPLE (which stands for Complement Hyperactivation, Angiopathic thrombosis, and Protein-Losing Enteropathy) disease is an ultra-rare inherited immune disease that causes the complement system to become overactive.[2-4] It is caused by biallelic loss-of-function variants in the CD55 gene, which leads to loss of protein expression and can result in the complement system attacking the body's own cells. There are fewer than 100 patients diagnosed worldwide with CHAPLE disease; it is estimated to impact around 10 patients in the US. Symptoms can include abdominal pain, nausea, vomiting, diarrhea, loss of appetite, weight loss, impaired growth, and edema. Severe thrombotic vascular occlusions (blockage of blood vessels) can also occur among patients with CHAPLE disease, which can be life-threatening. The condition mainly impacts children, including infants, and is associated with morbidity and a higher risk of mortality.

Dosing Information
Veopoz is administered by a healthcare provider.[1] On Day 1, give a single 30 mg/kg loading dose by intravenous infusion. Day 8 and thereafter, the maintenance dose is 10 mg/kg as a subcutaneous injection once weekly. The maintenance dosage may be increased to 12 mg/kg once weekly if there is inadequate clinical response after at least three weekly doses (starting from Week 4). The maximum maintenance dosage is 800 mg once weekly. Doses exceeding 400 mg require two injections.

Safety
Veopoz has a Boxed Warning regarding serious meningococcal infections.[1] Life-threatening and fatal meningococcal infections have occurred in patients treated with complement inhibitors. Complete or update meningococcal vaccination at least 2 weeks before administering the first dose of Veopoz, unless the risks of delaying therapy outweigh the risks of developing meningococcal infection. Follow the most current Advisory Committee on Immunization Practices (ACIP) recommendations for meningococcal vaccination in patients receiving a complement inhibitor. Also, patients treated with Veopoz may be at increased risk for invasive disease caused by *Neisseria meningitidis*, even if they develop antibodies following vaccination. Patients treated with Veopoz may be at increased risk of developing serious infections due to *Streptococcus pneumoniae* and *Haemophilus influenzae* type b infections; administer related vaccinations according to ACIP guidelines.

POLICY STATEMENT
Prior Authorization is recommended for medical benefit coverage of Veopoz. Approval is recommended for those who meet the **Criteria** and **Dosing** for the listed indication. Extended approvals are allowed if the patient continues to meet the Criteria and Dosing. Requests for doses outside of the established dosing

documented in this policy will be considered on a case-by-case basis by a clinician (i.e., Medical Director or Pharmacist). All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with Veopoz as well as the monitoring required for adverse events and long-term efficacy, approval requires Veopoz to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Documentation: Documentation is required for use of Veopoz as noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, laboratory data, genetic tests, and/or other information. All documentation must include patient-specific identifying information. Subsequent coverage reviews for a patient who has previously met the documentation requirement for the genetic test criterion in the *Complement Inhibitors – Veopoz Utilization Management Medical Policy* through the Coverage Review Department and who is requesting reauthorization, are NOT required to resubmit documentation for reauthorization regarding the genetic test criterion.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Veopoz is recommended in those who meet the following criteria:

FDA-Approved Indication

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1. **CD55-Deficient Protein-Losing Enteropathy (CHAPLE Disease [Complement Hyperactivation, Angiopathic thrombosis, and Protein-Losing Enteropathy]).** Approve for the duration noted below if the patient meets ONE of the following (A or B):
   - **A)** Initial Therapy. Approve for 3 months if the patient meets ALL of the following (i, ii, iii, iv, and v):
     - **i.** Patient is ≥ 1 year of age; AND
     - **ii.** Patient has had a genetic test confirming the diagnosis of CHAPLE disease with a biallelic CD55 loss-of-function pathogenic variant **[documentation required]**; AND
     - **iii.** Patient meets BOTH of the following (a and b):
       - **a)** Patient has a serum albumin level ≤ 3.2 g/dL **[documentation required]**; AND
       - **b)** According to the prescribing physician, the patient has active disease and is experiencing one or more signs or symptoms within the last 6 months; AND
         Note: Examples of signs and symptoms include abdominal pain, diarrhea, vomiting, peripheral edema, or facial edema.
     - **iv.** Medication is prescribed by a physician with expertise in managing CHAPLE disease; OR
   - **B)** Patient Currently Receiving Veopoz. Approve for 1 year if the patient meets ALL of the following (i, ii, iii, and iv):
     - **i.** Patient is ≥ 1 year of age; AND
     - **ii.** Patient has had a genetic test confirming the diagnosis of CHAPLE disease with a biallelic CD55 loss-of-function pathogenic variant **[documentation required]**; AND
     - **iii.** Medication is prescribed by a physician with expertise in managing CHAPLE disease; AND
     - **iv.** Patient had experienced a response to therapy **[documentation required]**.
       Note: Examples of a response to therapy include increased serum albumin levels, maintenance of serum albumin levels within a normal range, a reduction in albumin transfusions, increases in or maintenance of protein and/or immunoglobulin levels, improvement in clinical outcomes after receipt of therapy (e.g., decreases in the frequency of problematic abdominal pain, bowel

movement frequency, facial edema severity, and peripheral edema severity), reduced frequency in hospitalizations, increase in growth percentiles (e.g., body weight-for age and/or stature-for-age percentiles), and/or reduced use of corticosteroids.

Dosing. Approve a single 30 mg/kg loading dose by intravenous infusion on Day 1, followed by up to 12 mg/kg subcutaneously once weekly (up to a maximum of 800 mg).

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Veopoz is not recommended in the following situations:

1. **Concomitant Use with Other Complement Inhibitors.** In the pivotal study, use of other complement inhibitors was prohibited.

2. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Veopoz® intravenous infusion and subcutaneous injection [prescribing information]. Tarrytown, NY: Regeneron; March 2024.
2. Ozen A, Chongsrisawat V, Sefer AP, et al, for the Pozelimab CHAPLE working group. Evaluating the efficacy and safety of pozelimab in patients with CD55 deficiency with hyperactivation of complement, angiopathic thrombosis, and protein-losing enteropathy: an open-label, Phase 2 and 3 study. *Lancet*. 2024;403(10427):645-656.
3. Hoy SM. Pozelimab: first approval. *Drugs*. 2023;83(16):1551-1557.
4. Can S, Altunbas MY, Ozen A. Pharmacotherapy for CD55 deficiency with CHAPLE disease: how close are we to a cure? *Expert Opin Pharmacother*. 2024;25(11):1421-1426.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	--	09/08/2023
Annual Revision	No criteria changes.	09/04/2024
Selected Revision	For initial therapy, the requirement that the patient does not have a history of meningococcal infection was removed.	10/09/2024
Annual Revision	**CD55-Deficient Protein-Losing Enteropathy (CHAPLE Disease [Complement Hyperactivation, Angiopathic thrombosis, and Protein-Losing Enteropathy]):** The following requirements were removed that the patient has received or is in compliance with updated meningococcal vaccinations according to the most current Advisory Committee on Immunization Practices recommendations and that the patient has received or is in compliance with updated vaccinations for the prevention of Streptococcus pneumonia and Haemophilus influenza type b infections according to the most current Advisory Committee on Immunization Practices guidelines. For initial therapy and for a patient currently receiving Veopoz, the phrase "pathogenic variant" replaced "mutation".	09/03/2025