

PA Criteria	Criteria Details						
<b>Covered Uses (FDA approved indication)</b>	Uplizna is a CD19-directed cytolytic antibody indicated for the treatment of neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin- 4 (AQP4) antibody positive.						
<b>Exclusion Criteria</b>	None.						
<b>Required Medical Information</b>	Medical records supporting the request must be provided.						
<b>Age Restriction</b>	None.						
<b>Prescriber Restrictions</b>	None.						
<b>Coverage Duration</b>	Up to two years. Dose will be approved according to the FDA approved labeling or within accepted standards of medical practice.						
<b>Other Criteria/Information</b>	Refer to the Gold Coast Health Plan Medicare Part B Reference and Summary of Evidence document. <table border="1" data-bbox="500 863 1511 1010"> <thead> <tr> <th>HCPCS</th> <th>Description</th> <th>Billing Units/How Supplied</th> </tr> </thead> <tbody> <tr> <td>J1823</td> <td>Uplizna (inebilizumab-cdon)</td> <td><b>Billing unit: 1 mg</b>  100 mg/10 mL SDV</td> </tr> </tbody> </table>	HCPCS	Description	Billing Units/How Supplied	J1823	Uplizna (inebilizumab-cdon)	<b>Billing unit: 1 mg</b>  100 mg/10 mL SDV
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STATUS	DATE REVISED	REVIEW DATE	APPROVED/REVIEWED BY	EFFECTIVE DATE
Created	3/26/2025	3/26/2025	Dawn Shojai, PharmD, Senior Pharmacy Benefit Consultant (PSG)	N/A
Approved	N/A	8/21/2025	Pharmacy & Therapeutics (P&T) Committee	8/21/2025