



Effective Date 1/15/2025

Coverage Policy Number IP0219

Belatacept

Table of Contents

Overview	1
Medical Necessity Criteria	1
Reauthorization Criteria	2
Authorization Duration	2
Conditions Not Covered.....	2
Background.....	2
Coding Information	3
References	4
Revision Details	4

Related Coverage Resources

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment and have discretion in making individual coverage determinations. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This policy supports medical necessity review for belatacept for intravenous infusion (**Nulojix®**).

Medical Necessity Criteria

Belatacept for intravenous infusion (Nulojix) is considered medically necessary when the following are met:

1. **Kidney Transplantation – Prophylaxis of Organ Rejection.** Individual meets **ALL** of the following criteria (A, B and C):
 - A. Age 18 years or older
 - B. Individual is Epstein-Barr virus (EBV) seropositive
 - C. Nulojix is prescribed by, or in consultation with, a transplant specialist physician or a physician associated with a transplant center

Dosing. Approve the following dosing regimen (A and B):

- A. Each individual dose must not exceed 10 mg/kg administered by intravenous infusion; AND
- B. Nulojix is administered no more than four times in the first 4 weeks (day of transplant, Day 5, end of Week 2, and end of Week 4), and then no more frequently than once every 4 weeks.

2. **Solid Organ Transplantation Other Than Kidney – Prophylaxis of Solid Organ Rejection in a Patient Currently Receiving Nulojix.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):

- A. Patient is ≥ 18 years of age; AND
- B. Patient is Epstein-Barr virus (EBV) seropositive; AND
- C. Nulojix is prescribed by, or in consultation with, a transplant specialist physician or a physician associated with a transplant center.

Dosing. Approve the following dosing regimen (A and B):

- A. Each individual dose must not exceed 10 mg/kg administered by intravenous infusion; AND
- B. Nulojix is administered no more than four times in the first 4 weeks (day of transplant, Day 5, end of Week 2, and end of Week 4), and then no more frequently than once every 4 weeks.

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Reauthorization Criteria

Continuation of Belatacept for intravenous infusion (Nulojix) is considered medically necessary for **ALL** covered diagnosis when the above medical necessity criteria are met AND there is documentation of beneficial response.

Authorization Duration

Initial approval duration:

- 1. Kidney Transplantation – Prophylaxis of Organ Rejection: up to 4 months.
- 2. Solid Organ Transplantation Other Than Kidney – Prophylaxis of Solid Organ Rejection in a Patient Currently Receiving Nulojix: up to 12 months

Reauthorization approval duration:

- 1. Kidney Transplantation – Prophylaxis of Organ Rejection: up to 12 months
- 2. Solid Organ Transplantation Other Than Kidney – Prophylaxis of Solid Organ Rejection in a Patient Currently Receiving Nulojix: up to 12 months

Conditions Not Covered

Any other use is considered experimental, investigational or unproven (criteria will be updated as new published data are available).

Background

OVERVIEW

Nulojix, a selective T-cell costimulation blocker, is indicated for **prophylaxis of organ rejection** in patients ≥ 18 years of age receiving a kidney transplant.¹ Nulojix is to be used in conjunction with basiliximab, mycophenolate mofetil, and corticosteroids.

The prescribed dose must be evenly divisible by 12.5 mg.¹ Use of higher than recommended doses or more frequent administration is not recommended due to the increased risk of post-transplant lymphoproliferative

disorder predominately of the central nervous system (CNS), progressive multifocal leukoencephalopathy, and serious CNS infections. The dose is based on actual body weight of the patient at the time of transplantation and should not be modified during the course of treatment unless the patient's weight changes by > 10%.

Guidelines

Nulojix is not included in the guidelines. In 2009, the Kidney Disease Improving Global Outcomes (KDIGO) published extensive clinical practice guidelines for the care of kidney transplant recipients.² For maintenance therapy, it is recommended to employ a combination of immunosuppressive medications including a calcineurin inhibitor and an anti-proliferative agent, with or without corticosteroids. Compared to cyclosporine, tacrolimus reduces the risk of acute rejection and improves graft survival within the first year of transplantation. Tacrolimus is the first-line calcineurin inhibitor and it is suggested that tacrolimus (or cyclosporine) be initiated before or at the time of transplantation, rather than delayed until the onset of graft function. Mycophenolate should be used first-line as an anti-proliferative agent. Patients who are at low immunological risk and who receive induction therapy should have corticosteroid therapy discontinued during the first week post-transplantation. If a mammalian Target of Rapamycin (mTOR) inhibitor (Zortress® [everolimus], Rapamune® [sirolimus]) is used, it should not be commenced until graft function is established and surgical wounds are healed. In the case of no reported acute rejection, the lowest doses of maintenance immunosuppressive medications should be maintained 2 to 4 months post-transplant. Calcineurin inhibitors should be continued. Of note, many of the medications require the monitoring of levels (e.g., calcineurin inhibitor, mycophenolate mofetil, mTOR inhibitors).

Safety

Nulojix labeling contains a boxed warning for post-transplant lymphoproliferative disorder; other malignancies and serious infections; and use in liver transplant recipients.¹ Patients receiving Nulojix are at increased risk of developing post-transplant lymphoproliferative disorder, particularly those without immunity to the Epstein-Barr virus (EBV). Nulojix should only be used in individuals who are EBV seropositive; do not use in individuals who are EBV seronegative or with unknown EBV status. Individuals receiving Nulojix are at increased risk of developing infections or malignancies due to immunosuppression. Nulojix should not be used in liver transplant recipients due to an increased risk of graft loss and death.

Liver Transplantation

Nulojix has a boxed warning stating that use in liver transplant recipients is not recommended due to an increase risk of graft loss and death.¹

In a partially-blinded, active-controlled, parallel group, Phase II trial (N = 260), patients receiving the first liver transplant were randomized 1:1:1:1:1 to basiliximab + Nulojix high-dose + mycophenolate mofetil; or Nulojix high-dose + mycophenolate mofetil; Nulojix low-dose + mycophenolate mofetil; tacrolimus + mycophenolate mofetil; or tacrolimus alone.³ The primary endpoint was the composite of acute rejection, graft loss, and death at 6 months. Secondary endpoints included the incidence, severity, treatment, and outcome of acute rejection at 12 months; graft loss and death at 12 months; and change in renal function over time. At 6 months, the frequency of the composite endpoint was higher in the Nulojix groups (42% to 48%) compared to the tacrolimus groups (15% to 38%), driven mostly by a higher rate of acute rejection with Nulojix. An external Data Monitoring Committee stopped further enrollment in the Nulojix low-dose arm due to an increase in graft loss and death compared to the other arms of the study; however patients already on Nulojix low-dose were allowed to continue at the discretion of the investigator. At 12 months, there was a higher rate of acute rejection and death in the Nulojix groups compared to tacrolimus + mycophenolate mofetil. The long-term extension phase was terminated early when the Data Monitoring Committee determined there was continued graft loss and death in the Nulojix high-dose group.

Coding Information

Note: 1) This list of codes may not be all-inclusive.

2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

HCPSC Codes	Description
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J0485	Injection, belatacept, 1 mg
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References

1. Nulojix® intravenous infusion [prescribing information]. Princeton, NJ: Bristol-Myers Squibb; July 2021.
2. Kidney Disease: Improving Global Outcomes (KDIGO) Transplant Work Group. KDIGO Clinical Practice Guideline for the Care of Kidney Transplant Recipients. *Am J Transplant*. 2009;9(Suppl 3):S1 – S157.
3. Klintmalm GB, Feng S, Lake JR, et al. Belatacept-Based Immunosuppression in *De Novo* Liver Transplant Recipients: 1-Year Experience From a Phase II Randomized Study. *Am J Transplant*. 2014;14:1817-1827.

Revision Details

Type of Revision	Summary of Changes	Date
Selected Revision	<p>Updated from “Prophylaxis of Organ Rejection” to “Kidney Transplantation – Prophylaxis of Organ Rejection.”</p> <p>Added dosing information for Kidney Transplantation – Prophylaxis of Organ Rejection.</p> <p>Added “Solid Organ Transplantation Other Than Kidney – Prophylaxis of Solid Organ Rejection in a Patient Currently Receiving Nulojix.” Added authorization duration of 12 months.</p> <p>Conditions Not Covered:</p> <p>Removed “Liver Transplantation. Nulojix has a boxed warning stating that use in liver transplant recipients is not recommended due to an increase risk of graft loss and death.”</p>	1/15/2025

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