

sibeprenlimab (Voyxact[®])

Policy # 00972

Original Effective Date: 07/01/2026

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Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the “Company”), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Investigational or experimental services are not covered. This includes any drug, device, procedure, or service provided under the investigational arm of a clinical trial or clinical study. These services are excluded from coverage under benefits.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member’s contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider sibeprenlimab (Voyxact[®])[†] for the treatment of immunoglobulin A nephropathy (IgAN) to be **eligible for coverage**.^{**}

Patient Selection Criteria

Coverage eligibility for sibeprenlimab (Voyxact) will be considered when the following criteria are met:

- **Initial**
 - Patient has a diagnosis of primary immunoglobulin A nephropathy (IgAN); AND
 - Patient is greater than or equal to 18 years of age; AND
 - Diagnosis has been confirmed by biopsy; AND
*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*
 - Patient is at high risk of disease progression, defined by meeting the following criteria:
 - Patient meets ONE of the following:
 - ❖ Proteinuria greater than 0.5 g/day; OR
 - ❖ Urine protein to creatinine ratio greater than or equal to 0.44 g/g; AND
 - Patient has been receiving the maximally tolerated dose of an angiotensin converting enzyme inhibitor (ACEi) (e.g., lisinopril, enalapril, benazepril, captopril, fosinopril, moexipril, perindopril, quinapril, ramipril, trandolapril) or angiotensin receptor blocker (ARB) (e.g., candesartan, irbesartan, losartan, olmesartan, telmisartan, valsartan) for greater than 90 days; AND
*(Note: These specific patient selection criteria are additional Company requirements for coverage eligibility and will be denied as not medically necessary** if not met.)*

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- Patient has an estimated glomerular filtration rate (eGFR) greater than or equal to 30 mL/min/1.73 m²
*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*
- **Continuation**
 - Patient has received an initial authorization for Voyxact; AND
 - According to the prescriber, patient is continuing to derive benefit from Voyxact. Examples of treatment benefits include reduction in urine protein-to-creatinine ratio from baseline or reduction in proteinuria from baseline.
*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*

When Services Are Considered Not Medically Necessary

Based on review of available data, the Company considers the use of sibeprenlimab (Voyxact) when the diagnosis has not been confirmed by biopsy, the patient does not meet criteria defining a high risk of progression, or has an eGFR less than 30 mL/min/1.73 m² to be **not medically necessary**.**

Based on review of available data, the Company considers the continued use of sibeprenlimab (Voyxact) when the patient is not continuing to derive benefit from the drug to be **not medically necessary**.**

When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Company considers the use of sibeprenlimab (Voyxact) when the patient selection criteria are not met (except those denoted above as **not medically necessary****) to be **investigational**.*

Background/Overview

Voyxact is a proliferation-inducing ligand (APRIL) blocker indicated to reduce proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk for disease progression. By blocking APRIL, Voyxact ultimately reduces levels of serum galactose-deficient immunoglobulin A1 to address the cause of IgAN. It should be dosed as one 400 mg injection administered subcutaneously every 4 weeks.

IgAN is the most common cause of primary glomerulonephritis in resource-abundant settings. Around 25% of patients with this condition have a slow progression to end-stage kidney disease (ESKD) within 25 years of presentation. The remaining patients enter a sustained remission or have persistent low-grade hematuria and/or proteinuria. Some of the proposed risk factors for disease progression include proteinuria above 0.5 g/day, hypertension, reduced eGFR, hematuria, certain histologic predictors on kidney biopsy, and modifiable factors such as obesity, hypertriglyceridemia, and smoking. The goal of treating IgAN is to prevent disease progression to ESKD by reducing proteinuria to less than 0.5 to 1 g/day and resolving microscopic hematuria. The first-line treatment

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options to achieve this goal are supportive care with blood pressure control, maximally tolerated renin-angiotensin system blockade, treatment with a sodium-glucose cotransporter-2 (SGLT2) inhibitor, and lifestyle modification. After 3-6 months of optimized supportive care, patients at high risk may require further therapy to reduce risk. Several agents that target IgAN-specific pathogenic mechanisms have been approved recently for the treatment of IgAN in patients at risk of disease progression. These include budesonide (Tarpeyo[™])[‡], iptacopan (Fabhalta[®])[‡], sparsentan (Filspari[™])[‡], atrasentan (Vanrafia[™])[‡], and sibeprenlimab (Voyxact).

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

Voyxact was approved in November 2025 to reduce proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk for disease progression.

This indication is approved under accelerated approval based on reduction of proteinuria. It has not been established whether Voyxact slows kidney function decline over the long-term in patients with IgAN. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory clinical trial.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to regulations, other plan medical policies, and accredited national guidelines.

The effect of Voyxact on proteinuria was evaluated in a randomized, double-blind, placebo-controlled, multicenter, global study in adults with biopsy-confirmed IgAN, an eGFR ≥ 30 mL/min/1.73 m², proteinuria (defined as either urine protein/creatinine ratio based on 24-hour urine collection [uPCR-24h] ≥ 0.75 g/g or urine protein ≥ 1.0 g/day), and on a stable and maximally tolerated dose of an angiotensin-converting enzyme inhibitor (ACEi) and/or angiotensin receptor blocker (ARB) with or without a sodium-glucose co-transporter 2 inhibitor (SGLT2i). Patients with other glomerulopathies or those who had been treated with systemic immunosuppressants in the 16 weeks prior to screening were excluded. Patients were randomized 1:1 to receive either Voyxact or placebo injected subcutaneously once every 4 weeks.

The study enrolled a total of 510 patients. An interim analysis for efficacy was conducted on the first 320 randomized patients who had the opportunity to reach the Month 9 visit, 152 of whom were randomized to receive Voyxact while 168 were randomized to receive placebo. Baseline demographics and disease characteristics were generally balanced between treatment groups.

The primary endpoint was the relative change from baseline in uPCR-24h at Month 9. The mean estimated percent change from baseline was -50% in the Voyxact group and 2% in the placebo group. This corresponded to a 51% difference between groups (96.5% CI 43%, 58%) (p < 0.0001).

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References

1. Voyxact [package insert]. Otsuka America Pharmaceutical, Inc. Rockville, MD. Updated March 2026

Policy History

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06/04/2026 Medical Policy Committee review

06/10/2026 Medical Policy Implementation Committee approval. New policy.

Next Scheduled Review Date: 06/2027

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

- A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
- B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
 1. Consultation with technology evaluation center(s);
 2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
 3. Reference to federal regulations.

**Medically Necessary (or “Medical Necessity”) - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- A. In accordance with nationally accepted standards of medical practice;
- B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
- C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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‡ Indicated trademarks are the registered trademarks of their respective owners.

NOTICE: If the Patient's health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

NOTICE: If an authorization for an ongoing course of treatment has been provided to a member and the member changes from one health plan to another health plan (e.g., a member moves from carrier A to Louisiana Blue), Louisiana Blue may honor the previous health plan's authorization for the same service under the same type of in-network benefit for a 90-day transition period. Documentation of the authorization for the ongoing course of treatment from the previous health plan must be provided to us by the member or their provider and the services provided for the course of treatment must otherwise be a covered service under the Louisiana Blue health plan. This provision does not apply to medications covered under the plan's pharmacy benefit.