Clinical Policy: Navepegritide (Yuviwel)

Reference Number: CP.PHAR.746
Effective Date: 02.27.26
Last Review Date: 05.26
Line of Business: Commercial, HIM/ICHRA, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Navepegritide (Yuviwel®) is a prodrug of C-type natriuretic peptide (CNP).

FDA Approved Indication(s)

Yuviwel is indicated to increase linear growth in pediatric patients 2 years of age and older with achondroplasia with open epiphyses.*

** This indication is approved under accelerated approval based on an improvement in annualized growth velocity. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s).*

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Yuviwel is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Achondroplasia (must meet all)**:**

1. Diagnosis of achondroplasia with genetic testing confirming a mutation in the fibroblast growth factor receptor 3 (FGFR3) gene;
2. Prescribed by or in consultation with a pediatric endocrinologist;
3. Age ≥ 2 and < 12 years;
4. At the time of request, radiographic evidence indicates open epiphyses (growth plates);
5. Documentation of baseline annualized growth velocity, calculated based on standing height measured over the course of 6 months prior to request;
6. Documentation of member's current weight (in kg);
7. Yuviwel is not prescribed concurrently with any human growth hormone products (e.g., Genotropin®, Humatrope®, Norditropin®, Nutropin AQ®, Omnitrope®, Saizen®, Zomacton®);
8. Yuviwel is not prescribed concurrently with Voxzogo®;
9. Dose does not exceed both of the following (a and b):
   a. Weight-based weekly dosing (*see Section V. Dosage and Administration*);
   b. One of the following (i or ii):
      i. 1 vial per week;
      ii. Weight 56 to 90 kg: 2 vials per week.

Approval duration: 6 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Achondroplasia (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy as evidenced by improvement in annualized growth velocity from baseline;
3. Radiographic evidence within the last four months indicates that the member continues to have open epiphyses (growth plates);
4. Yuviwel is not prescribed concurrently with any human growth hormone products (e.g., Genotropin, Humatrope, Norditropin, Nutropin AQ, Omnitrope, Saizen, Zomacton);
5. Yuviwel is not prescribed concurrently with Voxzogo;
6. Documentation of member's current weight (in kg);
7. If request is for a dose increase, new dose does not exceed both of the following (a and b):
   a. Weight-based weekly dosing (*see Section V. Dosage and Administration*);
   b. One of the following (i or ii):
      i. 1 vial per week;
      ii. Weight 56 to 90 kg: 2 vials per week.

Approval duration: 6 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
CNP: C-type natriuretic peptide
FDA: Food and Drug Administration
FGFR3: fibroblast growth factor receptor 3

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings
None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Achondroplasia	SC once weekly based on body weight: • 8 to 9.9 kg: 0.88 mg/week • 10 to 13.4 kg: 1.2 mg/week • 13.5 to 17.5 kg: 1.6 mg/week • 17.6 to 23 kg: 2.1 mg/week • 23.1 to 30.5 kg: 2.8 mg/week • 30.6 to 41.2 kg: 3.6 mg/week • 41.3 to 55.9 kg: 5 mg/week	See dosing regimen

Indication	Dosing Regimen	Maximum Dose
	• 56 to 73.5 kg: 6.6 mg/week • 73.6 to 90 kg: 8.8 mg/week	

VI. Product Availability

Single-dose vials with lyophilized powder: 1.3 mg, 2.8 mg, 5.5 mg

VII. References

1. Yuviwel Prescribing Information. Hellerup, Denmark; Ascendis Pharma Growth Disorders A/S. February 2026. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2026/219164Orig1s000lbl.pdf. Accessed March 9, 2026.
2. Ascendis Pharma: TransCon™ CNP (navepegritide) ApproaCH Trial Topline Results. September 16, 2024. Available at: https://investors.ascendispharma.com/static-files/ac6e8fb8-8ab9-4c5c-b25c-14a90f766b48. Accessed July 31, 2025.
3. A clinical trial to evaluate efficacy and safety of TransCon CNP compared with placebo in children with achondroplasia (ApproaCH). ClinicalTrials.gov, identifier NCT05598320. Available at: https://clinicaltrials.gov/study/NCT05598320. Accessed July 31, 2025.
4. Savarirayan R, Hoernschemeyer DG, Ljungberg M, et al. Once-weekly TransCon CNP (navepegritide) in children with achondroplasia (ACcomplisH): a phase 2, multicentre, randomised, double-blind, placebo-controlled, dose-escalation trial. Lancet. 2023; 65: 1-10.
5. A dose escalation trial evaluating safety, efficacy, and pharmacokinetics of TransCon CNP administered once weekly in prepubertal children with achondroplasia. ClinicalTrials.gov, identifier NCT04085523. U.S. National Library of Medicine, May 22, 2025. Available at: https://clinicaltrials.gov/study/NCT04085523. Accessed July 30, 2025.
6. Hoover-Fong J, Scott CI, Jones MC, AAP Committee on Genetics. Health supervision for people with achondroplasia. *Pediatrics.* 2020;145(6):e20201010.
7. Savarirayan R, Ireland P, Irving M, et al. International Consensus Statement on the diagnosis, multidisciplinary management and lifelong care of individuals with achondroplasia. Nat Rev Endocrinol. 2022;18(3):173-189.
8. Savarirayan R, McDonnel C, Bacino CA, et al. Once-weekly navepegritide in children with achondroplasia: The APPROACH randomized clinical trial. *JAMA Pediatr*. 2026;180(1):18-25. doi:10.1001/jamapediatrics.2025.4771
9. Savarirayan R, Bacino C, McDonnell C, et al. 004: Growth outcomes and safety of navepegritide in children with achondroplasia: 2-year results of the ApproaCH trial open-label extension. Genetics in Medicine Open. 2026; 4(1). https://doi.org/10.1016/j.gimo.2026.104288

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J3590	Unclassified biologics

HCPCS Codes	Description
C9399	Unclassified drugs or biologicals

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created pre-emptively	07.30.25	11.25
RT1: Drug is now FDA approved – criteria updated per prescribing information to include weight-based dosing and quantity limits; added to continued therapy requirement that Yuviwel is not prescribed concurrently with Voxzogo and any human growth hormone products; added ICHRA line of business; references reviewed and updated.	04.07.26	05.26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise

professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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