Clinical Policy: Pegzilarginase-nbln (Loargys)

Reference Number: CP.PHAR.587
Effective Date: 02.23.26
Last Review Date: 08.26
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

Pegzilarginase-nbln (Loargys®) is a recombinant human arginase 1 enzyme.

FDA Approved Indication(s)

Loargys is indicated for the treatment of hyperargininemia in adult and pediatric patients 2 years of age and older with arginase 1 deficiency (ARG1-D), in conjunction with dietary protein restriction.

This indication is approved under accelerated approval based on reduction of plasma arginine. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.

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 Loargys is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Arginase 1 Deficiency (must meet all)**:**

1. Diagnosis of ARG1-D confirmed by one of the following (a or b):
   a. Genetic confirmation of an *ARG1* pathogenic variant;
   b. Documentation of reduced arginase enzyme activity in red blood cells;
2. Prescribed by or in consultation with a neurologist or physician experienced in treating metabolic disorders;
3. Age ≥ 2 years;
4. Provider attestation that member is currently adherent to a protein-restricted diet and will continue this diet during treatment with Loargys;
5. Documentation of plasma arginine level from within the last 3 months;
6. Documentation of member's current weight in kg;
7. Dose does not exceed 0.2 mg/kg once weekly.

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

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. Arginase 1 Deficiency (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 a reduction in plasma arginine levels since initiation of therapy;
3. Provider attestation that member has been adherent to a protein-restricted diet and will continue this diet during treatment with Loargys;
4. If request is for a dose increase, new dose does not exceed 0.2 mg/kg once weekly.

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

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
ARG1-D: arginase 1 deficiency
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): none reported
- Boxed warning(s): hypersensitivity reactions including anaphylaxis

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
ARG1-D	IV: Recommended starting dose of 0.1 mg/kg IV once weekly. To maximize the time within the normal range of 40 to 115 micromolar (μM), dose adjustments should be aimed at achieving a pre-dose level of plasma arginine near the upper limit of normal. After four weeks of administration, measure pre-dose plasma arginine (168 hours after prior dose) to determine the need for dosage adjustment. If two consecutive weekly pre-dose plasma arginine measurements are not in the desired therapeutic range, increase or decrease the weekly dosage as follows: • < 50 μM: Reduce the weekly dosage by 0.05 mg/kg. • > 150 μM: Increase the weekly dosage by 0.05 mg/kg.	0.2 mg/kg/week

Indication	Dosing Regimen	Maximum Dose
	SC: After 8 weeks of once weekly IV administration, patients may be switched to once weekly SC dosing at the same dosage of IV therapy.	

VI. Product Availability

Single-dose vials for injection: 2 mg/0.4 mL, 5 mg/mL

VII. References

1. Loargys Prescribing Information. Chicago, IL: Immedica Pharma US Inc.; February 2026. Available at: https://www.immedicaus.com/sites/default/files/pr/highlights-of-prescribing-information-loargys.pdf. Accessed May 11, 2026.
2. Russo RS, Gasperini S, Bubb G, et al. Efficacy and safety of pegzilarginase in arginase 1 deficiency (PEACE): a phase 3, randomized, double-blind, placebo-controlled, multi-centre trial. EClinicalMedicine. 2024;68:102405.
3. Haberle J, Burlina A, Chakrapani A, et al. Suggested guidelines for the diagnosis and management of urea cycle disorders: first revision. J Inherit Metab Dis. 2019;42(6):1192-1230. doi:10.1002/jimd.12100.
4. Sun A, Crombez EA, Wong D. Arginase deficiency. 2004 Oct 21 [Updated 2020 May 28]. GeneReviews® [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2026.

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
C9399	Unclassified drugs or biologicals
J3590	Unclassified biologics

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created pre-emptively	05.24.22	08.22
Template changes applied to other diagnoses/indications and continued therapy section.	09.19.22	
3Q 2023 annual review: no significant changes as drug is not yet FDA-approved; references reviewed and updated.	05.08.23	08.23
3Q 2024 annual review: no significant changes as drug is not yet FDA-approved; references reviewed and updated.	05.21.24	08.24
3Q 2025 annual review: no significant changes as drug is not yet FDA-approved; references reviewed and updated.	04.15.25	08.25

Reviews, Revisions, and Approvals	Date	P&T Approval Date
RT4: Drug is now FDA approved – criteria updated per FDA labeling: added criterion for member's current weight; added option of neurologist specialty; added ICHRA line of business; extended initial approval duration for Medicaid/HIM from 6 months to 12 months; revised initial and continued Commercial approval durations 6 and 12 months to "6 months or to the member's renewal date, whichever is longer"; added HCPCS codes; references reviewed and updated.	03.24.26	
3Q 2026 annual review: no significant changes; references reviewed and updated.	05.11.26	08.26

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.