Clinical Policy: Zilurgisertib (Atebrioz)

Reference Number: CP.PHAR.796
Effective Date: 09.25.26
Last Review Date: 08.26
Line of Business: Commercial, HIM/ICHRA, Medicaid Revision Log

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

Description

Zilurgisertib (Atebrioz™) is an activin receptor-like kinase 2 (ALK2) inhibitor.

FDA Approved Indication(s)

Atebrioz is indicated to reduce the volume of total new heterotopic ossification (HO) in adults and pediatric patients aged 12 years and older with fibrodysplasia ossificans progressiva (FOP).

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

I. Initial Approval Criteria

A. Fibrodysplasia Ossificans Progressiva (must meet all)**:**

1. Diagnosis of FOP;
2. Prescribed by or in consultation with a pediatric or adult orthopedics, orthopedic surgery, rheumatology, endocrinology, medical genetics, or metabolic disease specialist;
3. Age ≥ 12 years;
4. Presence of *ACVR1* mutation (e.g., R206H, *see Appendix D*);
5. Documentation of baseline heterotopic ossification (HO) volume assessed by low-dose whole body computed tomography (WBCT) scan, excluding the head;
6. Member has a cumulative analog joint involvement scale (CAJIS) score ≤ 23 prior to treatment with Atebrioz (*see Appendix E*);
7. Atebrioz is not prescribed concurrently with Sohonos™ or Pasatru™;
8. Dose does not exceed 100 mg (4 tablets) per day.

Approval duration: 12 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. Fibrodysplasia Ossificans Progressiva (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 one of the following (a, b, or c):
   a. Reduction in flare-ups from baseline;
   b. Improvement in new HO volume as assessed by low-dose WBCT scan;
   c. Increased or stabilized mobility;
3. Atebrioz is not prescribed concurrently with Sohonos or Pasatru;
4. If request is for a dose increase, new dose does not exceed 100 mg (4 tablets) per day.

Approval duration: 12 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

CAJIS: cumulative analog joint involvement scale
FDA: Food and Drug Administration
FOP: fibrodysplasia ossificans progressiva
HO: heterotopic ossification
NSAID: nonsteroidal anti-inflammatory drug
WBCT: whole body computed tomography

Appendix B: Therapeutic Alternatives

Not available

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): pregnancy
- Boxed warning(s): none reported

Appendix D: General Information

- Compassionate Use Program
  - Individuals with FOP, ages 12 and over, living in the United States, may be able to use zilurgisertib through a new Compassion Use Program opened by Mirum and Incyte: https://mirumpharma.com/our-science/pipeline.
- In the PROGRESS trial (NCT05090891), most enrolled patients had the R206H *ACVR1* mutation; however, other pathogenic *ACVR1* variants were also included.

Appendix E: CAJIS Score

CAJIS is an assessment of mobility limitation at 15 anatomic locations. Scores are tabulated for each site as normal unaffected (0), affected (1), or completely functionally ankylosed (2). The total score ranges from 0 to 30. Based on FOP features (flare-up activity, body regions affected, thoracic insufficiency syndrome, other complications) and its consequences (impairments in activities of daily living and ambulation, increasing CAJIS), five clinical stages of disease severity have been defined.

CAJIS Score	FOP Clinical Stage
≤ 4	Early
5–18	Moderate
19–24	Severe
≥ 24	Profound
≥ 28	End-of-life

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
FOP	100 mg PO QD Reduce to 50 mg PO QD when used concomitantly with a strong CYP3A4 inhibitor	100 mg/day

VI. Product Availability

Tablet: 25 mg

VII. References

1. Atebrioz Prescribing Information. Foster City, CA: Mirum Pharmaceuticals, Inc; September 2026. Available at: https://files.mirumpharma.com/atebrioz/Atebrioz-USPI-MedGuide.pdf. Accessed October 5, 2026.
2. ClinicalTrials.gov. To Assess the Efficacy, Safety, and Tolerability of INCB000928 in Participants with Fibrodysplasia Ossificans Progressiva (Progress). Available at: https://clinicaltrials.gov/study/NCT05090891?intr=%22INCB00928%22%20OR%20%22Zilurgisertib%22&viewType=Table&rank=1#study-overview. Accessed October 5, 2026.
3. Kaplan FS, Al Mukaddam M, Baujat G, et al. The medical management of fibrodysplasia ossificans progressiva: current treatment considerations. Proc Intl Clin Council FOP; 2024. Available at: https://static1.squarespace.com/static/685c549822246d50e494a3ce/t/690ba2c98c6cdf38e48d2331/1762374949941/ICCFOP_Guidelines_July2024.pdf. Accessed October 5, 2026.
4. Kaplan FS, Al Mukaddam M, Baujat G, et al. Medical guidelines for fibrodysplasia ossificans progressiva. *JBMR Plus.* 2025;9(11):ziaf150. doi:10.1093/jbmrpl/ziaf150.
5. Pignolo RJ, Li C, Bachiller-Corral FJ, et al. Zilurgisertib in patients with fibrodysplasia ossificans progressiva: interim results from the PROGRESS study. Presented at: Endocrine Society Annual Scientific Meeting (ENDO 2026); June 2026; Chicago, IL.
6. Pignolo RJ, Li C, Bachiller-Corral FJ, et al. Zilurgisertib in patients with fibrodysplasia ossificans progressiva: interim results from the PROGRESS study. Poster presented at: Endocrine Society Annual Scientific Meeting (ENDO 2026); June 2026; Chicago, IL.
7. Pignolo RJ, Kaplan FS. Clinical staging of Fibrodysplasia Ossificans Progressiva (FOP). *Bone*. 2018;109:111-114. doi:10.1016/j.bone.2017.09.016.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created pre-emptively	07.14.26	08.26
RT4: Drug is now FDA approved – criteria updated per FDA labeling: added medical genetics to list of provider specialty options; for initial approval criteria, added requirement for CAJIS score ≤ 23 prior to treatment with Atebrioz; for initial therapy, specified documentation of baseline HO volume; for initial and continued therapy sections, added requirement that Atebrioz is not prescribed concurrently with Pasatru; added Appendix E for CAJIS scoring; references reviewed and updated.	10.05.26	

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.

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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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