Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:

Medical Benefit Drug

# Amyloidosis Therapies: Amvuttra™ (vutrisiran) and Onpattro® (patisiran)

*Effective: October 1, 2024*

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|---|---|
| **Guideline Type** | ☒ Prior Authorization<br>☐ Non-Formulary<br>☐ Step-Therapy<br>☐ Administrative |

**Applies to:**

**Commercial Products**

☐ Harvard Pilgrim Health Care Commercial products; Fax 617-673-0988

☐ Tufts Health Plan Commercial products; Fax 617-673-0988

CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

**Public Plans Products**

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax 617-673-0988

☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax 617-673-0939

☐ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax 617-673-0939

☒ Tufts Health One Care* – A Medicare-Medicaid Plan (a dual eligible product); Fax 617-673-0956

*The MNG applies to Tufts Health One Care members unless a less restrictive LCD or NCD exists.

**Senior Products**

☒ Harvard Pilgrim Health Care Stride Medicare Advantage; Fax 617-673-0956

☒ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); Fax 617-673-0956

☒ Tufts Medicare Preferred HMO, (a Medicare Advantage product); Fax 617-673-0956

☒ Tufts Medicare Preferred PPO, (a Medicare Advantage product); Fax 617-673-0956

**Note:** While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

## Overview

In polyneuropathy of hereditary transthyretin-mediated amyloidosis (hATTR-PN), amyloid fibrils deposit in the nervous system, leading to pain, muscle weakness, and autonomic dysfunction.

Approval of Onpattro was based on the APOLLO phase 3 trial in adults with polyneuropathy neuropathy impairment score 5 to 130, polyneuropathy disability score ≤3b, Karnofsky performance status at least 60%) caused by hATTR amyloidosis. Patients with prior liver transplant were excluded from the trial. Results were positive for Onpattro and demonstrate that treatment resulted in statistically significant improvements on multiple polyneuropathy scales, including modified Neurologic Impairment Score +7 (primary endpoint), compared to placebo.

Approval of Amvuttra was based on the HELIOS-A phase 3 trial in adults with polyneuropathy (neuropathy impairment score 5 to 130, polyneuropathy disability score ≤3b, Karnofsky performance status at least 60%) caused by hATTR with TTR mutation. Patients with prior liver transplant were excluded from the trial. For this trial, the placebo cohort from the APOLLO trial of Onpattro, was used as an external control group for this trial. Of note, between-group differences in the baseline modified neurologic impairment score between Amvuttra-treated patients and placebo-treated patients exist, and appears to represent that the Amvuttra-treated patients had less severe disease. Results were positive for Amvuttra and demonstrate that treatment resulted in statistically significant improvements on multiple polyneuropathy scales, including modified Neurologic Impairment Score +7 (primary endpoint), compared to placebo.

Currently no medication is Food and Drug Administration (FDA)-approved for the treatment of both cardiomyopathy and polyneuropathy of hATTR. Furthermore, there is not reliable evidence demonstrating safety or additive benefit of combining a transthyretin (TTR) silencer (inotersen, eplontersen, patisiran, vutrisiran), with a TTR stabilizer (tafamidis) in someone with cardiomyopathy and polyneuropathy; therefore, combination therapy is not routinely used.

**Food and Drug Administration - Approved Indications**

**Amvuttra (vutrisiran)** is a transthyretin-directed small interfering RNA indicated for the treatment of the polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults.

**Onpattro (patisiran)** contains a transthyretin-directed small interfering RNA and is indicated for the treatment of polyneuropathy of hereditary transthyretin-mediated amyloidosis (ATTR-FAP) in adults.

## Clinical Guideline Coverage Criteria

The plan may authorize coverage of Amvuttra or Onpattro when all of the following criteria are met:

1. Documented diagnosis of hereditary transthyretin-mediated amyloidosis

2. The Member is at least 18 years of age

**AND**

3. Documentation the Member is experiencing progressive peripheral sensory-motor polyneuropathy

**AND**

4. Prescribed by or in consultation with neurologist or a provider specializing in the treatment of amyloidosis

## Limitations

None

## Codes

The following code(s) require prior authorization:

**Table 1: HCPCS Codes**

| HCPCS Codes | Description |
|---|---|
| J0222 | Injection, patisiran, 0.1 mg |
| J0225 | Injection, vutrisiran, 1 mg |

## References


1. Adams D, Gonzalez-Duarte A, O'Riordan WD, et al. Patisiran, an RNAi therapeutic, for hereditary transthyretin amyloidosis. N Engl J Med. 2018;379(1):11-21.
2. Ando Y, Coelho T, Berk JL, et al. Guideline of transthyretin -related hereditary amyloidosis for clinicians. Orphanet Journal of Rare Diseases. 2013;8(31):1-18.
3. Amvuttra (vutrisiran) [package insert]. Cambridge, MA: Alnylam Pharmaceuticals, Inc.; January 2023.
4. Benson MD, Waddington-Cruz M, Berk J, et al. Inotersen treatment for patients with hereditary transthyretin amyloidosis. N Engl J Med. 2018;379(1):22-31.
5. Brannagan T, Wang AK, Coelho T, et al. Open label extension of the phase 3 study NEURO-TTR to assess the long-term efficacy and safety of inotersen in patients with hereditary transthyretin amyloidosis. Neurology. 2018;90(15 Suppl). Abstract P1.324.
6. Lasser KE, Mickle K, Chapman R, et al. Inotersen and patisiran for hereditary transthyretin amyloidosis: effectiveness and value. Evidence report. 2018 August 29. Available from Internet. Accessed 2018 September 12.
7. Onpattro (patisiran) [package insert]. Cambridge, MA: Alnylam Pharmaceuticals, Inc.; January 2023.
8. Suhr OB, Gonzalez-Duarte A, O'Riordan W, et al. Long-term use of patisiran, an investigational RNAi therapeutic, in patients with hereditary transthyretin-mediated amyloidosis: baseline demographics and interim data from global open label extension study. Presented at 2018 International Symposium on Amyloidosis. Kumamoto, Japan; 2018 March.


## Approval And Revision History

September 13, 2022: Reviewed by Pharmacy and Therapeutics Committee (P&T)

Subsequent endorsement date(s) and changes made:

- September 21, 2022: Reviewed by the Medical Policy Approval Committee (MPAC).
- December 22, 2022: Administrative update: Amvuttra code J0225 added, effective January 1, 2023
- September 12, 2023: Administrative update to separate out age and diagnosis requirements. Removed the Limitation "Any indications other than FDA-approved indications are considered experimental or investigational and will not be approved by the health plan." (effective 10/1/23).

- November 2023: Administrative Updates: Rebranded from Tufts Health Unify to Tufts Health One Care for 2024 and administrative update in support of calendar year 2024 Medicare Advantage and PDP Final Rule.
- August 13, 2024: No changes (eff 12/1/24).
- September 2024: Joint Medical Policy and Health Care Services UM Committee review (eff 10/1/24).

## Background, Product and Disclaimer Information

Point32Health prior authorization criteria to be applied to Medicare Advantage plan members is based on guidance from Medicare laws, National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). When no guidance is provided, Point32Health uses clinical practice guidance published by relevant medical societies, relevant medical literature, Food and Drug Administration (FDA)-approved package labeling, and drug compendia to develop prior authorization criteria to apply to Medicare Advantage plan members. Medications that require prior authorization generally meet one or more of the following criteria: Drug product has the potential to be used for cosmetic purposes; drug product is not considered as first-line treatment by medically accepted practice guidelines, evidence to support the safety and efficacy of a drug product is poor, or drug product has the potential to be used for indications outside of the indications approved by the FDA. Prior authorization and use of the coverage criteria within this Medical Necessity Guideline will ensure drug therapy is medically necessary, clinically appropriate, and aligns with evidence-based guidelines. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests revisions.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.