Inotersen (Tegsedi™)

Place of Service Self-Administration Pharmacy Benefit

HCPCS: J3490

NDCs:

- 72126-007-03: 284 mg/ 1.5 mL singledose prefilled syringe (pack of 1 syringe)
- 72126-007-01: 284 mg/ 1.5 mL singledose prefilled syringe (pack of 4 syringes)

Condition listed in policy (see criteria for details)

• Hereditary transthyretin amyloidosis (hATTR) with polyneuropathy

AHFS therapeutic class: Amyloidosis agent, transthyretin (TTR) suppression

Mechanism of action: Transthyretin-directed antisense oligonucleotide

(1) Special Instructions and pertinent Information

This drug is managed under the outpatient Pharmacy Benefit for self-administration. Please contact the member's Pharmacy Benefit for information on how to obtain this drug.

To submit a request to the Medical Benefit, please submit clinical information for prior authorization review and include medical rationale why the patient cannot self-administer this drug in the home.

For plans with self-injectables only covered under the Medical Benefit, please submit clinical information for prior authorization review.

(2) Prior Authorization/Medical Review is required for the following condition(s) All requests for inotersen (Tegsedi[™]) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

Hereditary transthyretin amyloidosis (hATTR) with polyneuropathy

- 1. Age 18 years or older, AND
- 2. Prescribed by or in consultation with a neurologist, AND
- 3. Documented diagnosis of hATTR with polyneuropathy confirmed by documentation of a pathogenic TTR mutation, **AND**
- 4. Patient has a baseline platelet count above 100 x 10⁹/L, AND

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- 5. Patient has a baseline urine protein to creatinine ratio (UPCR) below 1000 mg/g, AND
- 6. Not being used in combination with Onpattro or tafamidis

Covered Doses

284 mg SC once weekly

Coverage Period Indefinite

ICD-10: E85.1

(3) The following condition(s) <u>DO NOT</u> require Prior Authorization/Preservice All requests for inotersen (Tegsedi[™]) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

(4) This Medication is NOT medically necessary for the following condition(s)

Coverage for a Non-FDA approved indication, requires that criteria outlined in Health and Safety Code § 1367.21, including objective evidence of efficacy and safety are met for the proposed indication.

Please refer to the Provider Manual and User Guide for more information.

(5) Additional Information

How supplied:

• 284 mg/ 1.5 mL (single-dose prefilled syringe)

(6) References

- Adams D, Gonzalez-Duarte A, O'Riordan WD, et al. Patisiran, an RNAi therapeutic, for hereditary transthyretin amyloidosis.N Engl J Med 2018;379:11-21.
- Adams D, Suhr OB, Hund E, et al. First European consensus for diagnosis, management, and treatment of transthyretin familial amyloid polyneuropathy. Curr Opin Neurol. 2016;29(Suppl 1):S14-26.
- AHFS[®]. Available by subscription at <u>http://www.lexi.com</u>
- Benson MD, Waddington-Cruz M, Berk JL, et al. Inotersen treatment for patients with hereditary transthyretin amyloidosis. N Engl J Med 2018; 379: 22-31.
- Buxbaum JN. Oligonucleotide drugs for transthyretin amyloidosis. N Engl J Med 2018; 379:1.
- DrugDex®. Available by subscription at http://www.micromedexsolutions.com/home/dispatch
- Maurer MS, Schwartz JH, Gundapaneni B, et al. Tafamidis treatment for patients with transthyretin amyloid cardiomyopathy. N Engl J Med 2018; 379(11):1007-1016.
- Tegsedi[®] (patisiran) [Prescribing Information]. Waltham, MA: Akcea Therapeutics; 5/2021.

(7) Policy Update

Date of last review: 3Q2022 Date of next review: 3Q2023 Changes from previous policy version:

• No clinical change to policy following routine annual review.

BSC Drug Coverage Criteria to Determine Medical Necessity Reviewed by P&T Committee

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Effective: 08/03/2022

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