Medical Policy

Duchenne Muscular Dystrophy (DMD) Amondys 45 (casimersen) Exondys 51® (eteplirsen) Viltepso® (viltolarsen) Vyondys 53® (golodirsen)	
MEDICAL POLICY NUMBER	Med_Clin_Ops_050
CURRENT VERSION EFFECTIVE DATE	January 1, 2024
APPLICABLE PRODUCT AND MARKET	*Individual Family Plan:* All Plans *Small Group*: All Plans *Medicare Advantage:* All Plans

Brand New Day/Central Health Medicare Plan develops policies and makes coverage determinations using credible scientific evidence including but not limited to MCG™ Health Guidelines, the ASAM Criteria™, and other third party sources, such as peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and expert opinion as relevant to supplement those sources. Brand New Day/Central Health Medicare Plan Medical Policies, MCG™ Guidelines, and the ASAM Criteria™ are not intended to be used without the independent clinical judgment of a qualified health care provider considering the individual circumstances of each member's case. The treating health care providers are solely responsible for diagnosis, treatment, and medical advice. Members may contact Brand New Day/Central Health Medicare Plan Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Brand New Day/Central Health Medicare Plan Medical Policy may contact the Health Plan. Brand New Day/Central Health Medicare Plan policies and practices are compliant with federal and state requirements, including mental health parity laws.

If there is a difference between this policy and the member specific plan document, the member benefit plan document will govern. For Medicare Advantage members, Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), govern. Refer to the CMS website at http://www.cms.gov for additional information.

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PURPOSE

To promote consistency between reviewers in clinical coverage decision-making by providing the criteria that generally determine the medical necessity of Amondys 45, Exondys 51®, Viltepso®, and Vyondys 53® therapy.

POLICY/CRITERIA

Prior Authorization and Medical Review is required.

Coverage will be provided for 6 months and may be renewed. Coverage may be renewed and approved for 12 months.

Initial Therapy

1. Requested drug is prescribed by, or in consultation with, a neurologist who specializes in treatment of Duchenne muscular dystrophy (DMD); **AND**

2. Patient has a diagnosis of Duchenne muscular dystrophy (DMD); **AND**
3. **One** of the following**:**
    a. Submission of medical records (e.g., chart notes, laboratory values) confirming that the patient has a 6-Minute Walk Time (6MWT) ≥ 300 meters while walking independently (e.g., without side-by-side assist, cane, walker, wheelchair, etc.) prior to beginning therapy; **OR**
    a. **Both** of the following:
        a. North Star ambulatory assessment (NSAA) score of greater than 17: **AND**
        b. A time to rise from the floor (Gower's test) or less than 7 seconds; **AND**
4. Patient is currently receiving treatment with a glucocorticoid and **one** of the following conditions has been met: **[Documentation Required]**
    a. Member has received glucocorticoids for at least 6 months AND, according to the prescribing physician, the member has experienced at least **one** of the following significant intolerable adverse effects:
        i. Cushingoid appearance
        ii. Central (truncal) obesity
        iii. Undesirable weight gain (defined as ≥ 10% of body weight gain increase over a 6-month period)
        iv. Diabetes and/or hypertension that is difficult to manage according to the prescribing physician; **OR**
    b. According to the prescribing physician, the member has experienced a severe behavioral adverse effect while on glucocorticoid therapy that has (or would) require a dose reduction; **OR**
    c. Patient has had an inadequate response (as evidenced by a significant decline in 6MWT, or other functional test) despite adherent use of glucocorticoid therapy for at least 6 months; **AND**
5. Documentation (chart notes, medical records, etc.) of a confirmed mutation of the DMD gene that is amenable to exon 45 skipping (**Amondys 45 ONLY**); **OR**
6. Documentation (chart notes, medical records, etc.) of a confirmed mutation of the DMD gene that is amenable to exon 51 skipping (**Exondys 51 ONLY**); **OR**
7. Documentation (chart notes, medical records, etc.) of a confirmied mutation of the DMD gene that is amenable to exon 53 skipping (**Viltepso/Vyondys 53 ONLY**).

Continuation Therapy

1. Requested drug is prescribed by, or in consultation with, a neurologist with expertise in the treatment of DMD; **AND**
2. Updated documentation (recent progress notes documenting overall disease status and ambulatory status) has been provided showing that patient has demonstrated a response to
therapy as evidenced by remaining ambulatory (e.g., able to walk with or without assistance, not wheelchair dependent).

LIMITATIONS/EXCLUSIONS

1. Any indication other than those listed above due to insufficient evidence of therapeutic value.

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2. Coadministration with another exon skipping therapies for DMD.

BACKGROUND

Amondys 45 (casimersen) is designed to bind to exon 45 of dystrophin pre-mRNA, resulting in exclusion of this exon during mRNA processing in patients with genetic mutations that are amenable to exon 45 skipping. Approximately 8% of DMD patients have out-of frame deletion mutations amenable to exon 45 skipping. Exon skipping is intended to allow for production of an internally truncated dystrophin protein.

Exondys 51® (eteplirsen) was the first PMO approved by the US Food and Drug Administration for treatment of DMD patients with confirmed genetic mutations amenable to exon 51 skipping. Approximately 13% of DMD patients have out-of frame deletion mutations amenable to exon 51 skipping. This indication was approved under accelerated approval based on an increase in dystrophin in skeletal muscle observed in some patients treated with eteplirsen.

Viltepso® (viltolarsen), an antisense oligonucleotide, binds to exon 53 of dystrophin pre-mRNA resulting in exclusion of this exon during mRNA processing in patients with genetic mutations that are amendable to exon 53 skipping. Exon 53 skipping is intended to allow for production of internally truncated dystrophin protein in patients with genetic mutations amendable to exon 53 skipping.
This indication is approved under accelerated approval based on an increase in dystrophin production in skeletal muscle observed in patients treated with Viltepso. Continued approval for this indication
may be contingent upon verification and description of clinical benefit in a confirmatory trial.

Vyondys® (golodirsen) is designed to bind to exon 53 of dystrophin pre-mRNA resulting in exclusion of this exon during mRNA processing in patients with genetic mutations that are amenable to exon 53 skipping. Exon 53 skipping is intended to allow for production of an internally truncated dystrophin protein in patients with genetic mutations that are amenable to exon 53 skipping.

DEFINITIONS

1. AMONDYS 45 (casimersen) injection, for intravenous use. Initial U.S. Approval: 2021
    a. AMONDYS 45 injection is supplied in single dose vials. The solution is a clear to slightly opalescent, colorless liquid, and may contain trace amounts of small, white to off-white amorphous particles.
    b. Single-dose vials contain 100 mg/2 mL (50 mg/mL) casimersen
2. EXONDYS 51 (eteplirsen) injection, for intravenous use. Initial U.S. Approval: 2016
    a. EXONDYS 51 injection is supplied in single-dose vials. The solution is clear and colorless, and may have some opalescence, and may contain trace amounts of small, white to off-white amorphous particles.
    b. Single-dose vials contain 100 mg/2 mL (50 mg/mL) eteplirsen
    c. Single-dose vials contain 500 mg/10 mL (50 mg/mL) eteplirsen
3. VILTEPSO (viltolarsen) injection, for intravenous use. Initial U.S. Approval: 2020
    a. VILTEPSO injection is supplied in single-dose vials. The solution is clear and colorless.

   b. Single-dose vials contain 250 mg/5 mL (50 mg/mL) viltolarsen
4. VYONDYS 53 (golodirsen) injection, for intravenous use. Initial U.S. Approval: 2019
   a. VYONDYS 53 injection is supplied in single dose vials. The solution is a clear to slightly opalescent, colorless liquid, and may contain trace amounts of small, white to off-white amorphous particles.
   b. Single-dose vials contain 100 mg/2mL (50 mg/mL) golodirsen

CODING

Applicable NDC Codes	
60923-0227-02	Amondys, single use vial; 50mg/1mL solution for injection
60923-0363-02	Exondys, single use vial; 50mg/1mL solution for injection (2mL vial)
60923-0284-10	Exondys, single use vial; 50mg/1mL solution for injection (10mL vial)
73292-0011-01	Viltepso single dose vial containing 250mg/5ml (50mg/mL)
60923-0465-02	Vyondys, single use vial; 50 mg/mL powder for injection

Applicable Procedure Code	
J1428	Injection, eteplirsen, 10mg (EXONDYS 51®).
J1427	Injection, viltolarsen, 10mg (VILTEPSO)
J1429	Injection, golodirsen, 10 mg (VYONDYS 53®)
J1426	Injection, casimersen, 10 mg (AMONDYS 45). J-Code effective date: 10/01/2021

Applicable ICD-10 Codes	
G71.01	Duchenne or Becker Muscular Dystrophy

EVIDENCE BASED REFERENCES

1. Product Information: VILTEPSO(TM) intravenous injection, viltolarsen intravenous injection. NS Pharma Inc (per manufacturer), Paramus, NJ, 2020.
2. CureDuchenne. " Duchenne Population Potentially Amenable to Exon Skipping." https://www.cureduchenne.org/wp-content/uploads/2016/11/Duchenne-Population-Potentially-Amenable-to-Exon-Skipping-11.10.16.pdf
3. Kole R, Krieg AM. Exon skipping therapy for Duchenne muscular dystrophy. Adv Drug Deliv Rev. 2015; 87:104-107.
4. Landfeldt E, Lindgren P, Bell C, et al. The burden of Duchenne muscular dystrophy. Neurology. 2014; 83:529-536.
5. National Organization for Rare Disorders—Rare Disease Database. Danbury (CT): NORD. Duchenne Muscular Dystrophy. 2018 [cited 2019 Jan 25]. Available from: https://rarediseases.org/rare-diseases/duchenne-muscular-dystrophy/
6. Product Information: VYONDYS 53(TM) intravenous injection, golodirsen intravenous injection. Sarepta Therapeutics Inc (per FDA), Cambridge, MA, 2019.

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POLICY HISTORY

Original Effective Date	May 24, 2021
Revised Date	• January 7, 2022 – Added J-code (J1426): Injection, casimersen, 10 mg Effective Date: 10/01/2021 • February 28, 2023 – Annual review • January 1, 2024 - Updated to Brand New Day/Central Health Medicare Plan (no policy revisions made)

Approved by P&T Committee **2/28/23**