Medical Policy

Zolgensma® (onasemnogene abeparvovec-xioi)	
MEDICAL POLICY NUMBER	MED_Clin_Ops_025
CURRENT VERSION EFFECTIVE DATE	January 1, 2024
APPLICABLE PRODUCT AND MARKET	*Individual Family Plan:* All Plans *Small Group*: All Plans *Medicare Advantage:* All Plans

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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 Zolgensma ® (onasemnogene abeparvovec-xioi) therapy.

POLICY/CRITERA

Prior Authorization and Medical Review is required.

Coverage of Zolgensma is approved for patients for one treatment per lifetime for the treatment of spinal muscular atrophy (SMA) in patients who meet ALL the following criteria:

1. Submission of medical records (e.g., chart notes, laboratory values) confirming the following:
    a. The mutation or deletion of genes in chromosome 5q resulting in one of the following:

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i. Homozygous gene deletion or mutation of SMN1 gene (e.g., homozygous deletion of exon 7 at locus 5q13); **OR**
ii. Compound heterozygous mutation of SMN1 gene (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1[allele 2]); **AND**

2. One of the following:
    a. Diagnosis of symptomatic SMA by a neurologist with expertise in the diagnosis of SMA; **OR**
    b. Both of the following:
        i. Diagnosis of likely Type I or II SMA based on the results of SMA newborn screening; **AND**
        ii. Submission of medical records (e.g., chart notes, laboratory values) confirming that patient has 3 copies or less of SMN2 gene; **AND**
3. For use in a neonatal patient born prematurely, the full-term gestational age has been reached; **AND**
4. One of the following:
    a. Both of the following:
        i. Patient is less than or equal to 6 months of age; **AND**
        ii. Patient does not have advanced SMA at baseline (e.g., complete paralysis of limbs); **OR**
    b. All the following:
        i. Patient is greater than 6 months of age, but less than 2 years of age; **AND**
        ii. One of the following:
            1. Both of the following:
                a. Patient has previously received SMN modifying therapy [e.g., Spinraza (nusinersen), Evrysdi (risdiplam)] for the treatment of Type I, or likely Type I or II SMA before 6 months of age with positive clinical response; **AND**
                b. Submission of medical records (e.g., chart notes, laboratory values) confirming patient does not have advanced SMA as defined by the fact that the patient has

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not shown evidence of clinical decline while receiving SMN modifying therapy [e.g., Spinraza (nusinersen), Evrysdi (risdiplam)];

OR

2. Both of the following:

   a. Patient has previously received SMN modifying therapy [e.g., Spinraza (nusinersen), Evrysdi (risdiplam)] for the treatment of later-onset SMA before 2 years of age with positive clinical response; **AND**

   b. Submission of medical records (e.g., chart notes, laboratory values) confirming patient does not have advanced SMA as defined by the fact that the patient has not shown evidence of clinical decline while receiving SMN modifying therapy [e.g., Spinraza (nusinersen), Evrysdi (risdiplam)];

   OR

3. Patient has recently been diagnosed with symptomatic later-onset SMA within the previous 6 months.

iii. Submission of medical records (e.g., chart notes, laboratory values) confirming patient does not have advanced SMA as defined by the fact that patient's most recent CHOP INTEND score is greater than or equal to 40; **AND**

1. Patient is less than or equal to 13.5 kg; **AND**

2. Dose to be administered does not exceed one kit of Zolgensma; **AND**

5. Patient is not dependent on either of the following:

   a. Invasive ventilation or tracheostomy

   b. Use of non-invasive ventilation beyond use for naps and nighttime sleep; **AND**

6. Zolgensma is prescribed by a neurologist with expertise in the treatment of SMA; **AND**

7. Patient is not to receive routine concomitant SMN modifying therapy (e.g., Spinraza, Evrysdi) (patient's medical record will be reviewed and any current authorizations for

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SMN modifying therapy will be terminated upon Zolgensma approval; patient access to subsequent SMN modifying therapy will be assessed according to respective coverage policy of concomitant agent); **AND**

8. Physician attests that the patient will be assessed for the presence of anti-AAV9 antibodies and managed accordingly; **AND**
9. Physician attests that the patient will not receive Zolgensma if the most recent pre- treatment anti-AAV9 antibody titer is above 1:50; **AND**
10. Physician attests that the patient, while under the care of the physician, will be assessed by one of the following exam scales during subsequent office visits for a period not to exceed 3 years:
    a. Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND) scale during subsequent office visits while the patient is 2 to 3 years of age or younger; **OR**
    b. Hammersmith Functional Motor Scale Expanded (HFMSE) during subsequent office visits while the patient is 2 to 3 years of age or older; **AND**
11. Liver function tests, platelet counts, and troponin-I levels will be obtained in accordance with the United States Food and Drug Administration (FDA) approved Zolgensma labeling; AND
12. Physician acknowledges that Bright Health Plan may request documentation, not more frequently than biannually, of follow-up patient assessment(s) including, but not necessarily limited to, serial CHOP INTEND or HFMSE assessments while the patient is under the care of the physician; **AND**
13. Patient will receive prophylactic prednisolone (or glucocorticoid equivalent) one day prior to and 30 days following receipt of Zolgensma in accordance with the United States Food and Drug Administration (FDA) approved Zolgensma labeling; **AND**
14. Patient will receive Zolgensma intravenously in accordance with the FDA approved labeling, 1.1 x 10^{14} vector genomes (vg) per kg of body weight; **AND**
15. Patient has never received Zolgensma treatment in their lifetime; **AND**
16. Authorization will be for no longer than 14 days from approval or until 2 years of age, whichever is first, and may not be renewed.

LIMITATIONS/EXCLUSIONS

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

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2. Age older than 2 years of age.
3. Combination treatment of SMA with concomitant SMN modifying therapy (e.g. Spinraza, Evrysdi) or past treatment with a SMN modifying therapy.
4. Patient has previously received a gene therapy for SMA.
5. Dose greater than one kit of Zolgensma.
6. Pre-symptomatic treatment for patients who are unlikely to develop Type 1 or Type 2 SMA.
7. SMA without chromosome 5q mutations or deletions.
8. Safety and effectiveness of repeat administration of Zolgensma have not been evaluated.
9. Safety and effectiveness of use of Zolgensma in patients with advanced SMA (e.g., complete paralysis of limbs, permanent ventilator-dependence) has not been evaluated.

BACKGROUND

ZOLGENSMA (onasemnogene abeparvovec-xioi) is an adeno-associated virus vector-based gene therapy indicated for the treatment of pediatric patients less than 2 years of age with spinal muscular atrophy (SMA) with bi-allelic mutations in the survival motor neuron 1 (SMN1) gene.

DEFINITIONS

1. ZOLGENSMA® (onasemnogene abeparvovec-xioi) Suspension for intravenous infusion Initial U.S. Approval: 2019
   a. ZOLGENSMA is a suspension for intravenous infusion, supplied as single-use vials.
   b. ZOLGENSMA is provided in a kit containing 2 to 9 vials, as a combination of 2 vial fill volumes (either 5.5 mL or 8.3 mL). All vials have a nominal concentration of 2.0 × 1013 vector genomes (vg) per mL.
   c. Each vial of ZOLGENSMA contains an extractable volume of not less than either 5.6 mL or 8.3 mL.

CODING

Applicable NDC Codes	
71894-0120-xx	Zolgensma 2.6-3.0 kg Intravenous Kit (2x8.3 mL)
71894-0121-xx	Zolgensma 3.1-3.5 kg Intravenous Kit (2x5.5mL & 1x8.3mL)
71894-0122-xx	Zolgensma 3.6-4.0 kg Intravenous Kit (1x5.5mL & 2x8.3mL)
71894-0123-xx	Zolgensma 4.1-4.5 kg Intravenous Kit (3x8.3 mL)
71894-0124-xx	Zolgensma 4.6-5.0 kg Intravenous Kit (2x5.5mL & 2x8.3mL)
71894-0125-xx	Zolgensma 5.1-5.5 kg Intravenous Kit (1x5.5mL & 3x8.3mL)
71894-0126-xx	Zolgensma 5.6-6.0 kg Intravenous Kit (4x8.3 mL)
71894-0127-xx	Zolgensma 6.1-6.5 kg Intravenous Kit (2x5.5mL & 3x8.3mL)
71894-0128-xx	Zolgensma 6.6-7.0 kg Intravenous Kit (1x5.5mL & 4x8.3mL)
71894-0129-xx	Zolgensma 7.1-7.5 kg Intravenous Kit (5x8.3 mL)

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71894-0130-xx	Zolgensma 7.6-8.0 kg Intravenous Kit (2x5.5mL & 4x8.3mL)
71894-0131-xx	Zolgensma 8.1-8.5 kg Intravenous Kit (1x5.5mL & 5x8.3mL)
71894-0132-xx	Zolgensma 8.6-9.0 kg Intravenous Kit (6x8.3 mL)
71894-0133-xx	Zolgensma 9.1-9.5 kg Intravenous Kit (2x5.5mL & 5x8.3mL)
71894-0134-xx	Zolgensma 9.6-10.0 kg Intravenous Kit (1x5.5mL & 6x8.3mL)
71894-0135-xx	Zolgensma 10.1-10.5 kg Intravenous Kit (7x8.3 mL)
71894-0136-xx	Zolgensma 10.6-11.0 kg Intravenous Kit (2x5.5mL & 6x8.3mL)
71894-0137-xx	Zolgensma 11.1-11.5 kg Intravenous Kit (1x5.5mL & 7x8.3mL)
71894-0138-xx	Zolgensma 11.6-12.0 kg Intravenous Kit (8x8.3 mL)
71894-0139-xx	Zolgensma 12.1-12.5 kg Intravenous Kit (2x5.5mL & 7x8.3mL)
71894-0140-xx	Zolgensma 12.6-13.0 kg Intravenous Kit (1x5.5mL & 8x8.3mL)
71894-0141-xx	Zolgensma 13.1-13.5 kg Intravenous Kit (9x8.3 mL)

Applicable Procedure Code	
J3399	Injection, onasemnogene abeparvovec-xioi, per treatment, up to 5x10^15 vector genomes

Applicable ICD-10 Codes	
G12.0	Infantile spinal muscular atrophy, type I [Werdnig-Hoffmann]
G12.1	Other inherited spinal muscular atrophy
G12.9	Spinal muscular atrophy, unspecified

EVIDENCE BASED REFERENCES

1. Product Information: ZOLGENSMA(R) intravenous suspension, onasemnogene abeparvovec-xioi intravenous suspension. AveXis Inc (per manufacturer), Bannockburn, IL, 2019.

POLICY HISTORY

Original Effective Date	September 30, 2019
Revised Date	December 7, 2020 - Added updated mutations, requirements November 1, 2021 – Annual Review and approval (no policy revisions made) February 2, 2022 – Annual Review and approval (no policy revisions made) February 28, 2023 – Annual Review and approval (no policy revisions made) March 1, 2023 – Adopted by MA UM Committee (no policy revisions made) January 1, 2024 - Updated to Brand New Day/Central Health Medicare Plan (no policy revisions made)

Approved by Pharmacy and Therapeutics Committee on 2/28/2023

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