Tegsedi™ (inotersen)
(Subcutaneous)

Document Number: IC-0401

Last Review Date: 10/30/2018
Date of Origin: 10/30/2018
Dates Reviewed: 11/2018

I. Length of Authorization

Coverage will be provided for six months and may be renewed.

II. Dosing Limits

A. Quantity Limit (max daily dose) [Pharmacy Benefit]:

- Tegsedi 284 mg/1.5 mL single-dose prefilled syringe: 1 prefilled syringe every 7 days

B. Max Units (per dose and over time) [Medical Benefit]:

- 284 mg every 7 days

III. Initial Approval Criteria

Coverage is provided in the following conditions:

- Patient has a platelet count of ≥ 100 X 10^9/L; **AND**
- Patient has a baseline urine protein to creatinine ratio (UPCR) of ≤ 1000 mg/g; **AND**
- Patient is enrolled in the Tegsedi REMS program; **AND**
- Must not be used in combination with other transthyretin (TTR) reducing agents (e.g., patisiran, etc.); **AND**

Polyneuropathy due to Hereditary Transthyretin-Mediated (hATTR) Amyloidosis /Familial Amyloidotic Polyneuropathy (FAP) †

- Patient must be at least 18 years old; **AND**
- Patient has a definitive diagnosis of hATTR amyloidosis/FAP as documented by amyloid deposition on tissue biopsy and identification of a pathogenic *TTR* variant using molecular genetic testing; **AND**
- Used for the treatment of polyneuropathy as demonstrated by at least TWO of the following criteria:

- Subjective patient symptoms are suggestive of neuropathy
- Abnormal nerve conduction studies are consistent with polyneuropathy
- Abnormal neurological examination is suggestive of neuropathy; **AND**

- Patient's peripheral neuropathy is attributed to hATTR/FAP and other causes of neuropathy have been excluded; **AND**
- Baseline in strength/weakness has been documented using an objective clinical measuring tool (e.g., Medical Research Council (MRC) muscle strength, etc.); **AND**
- Patient has not been the recipient of an orthotopic liver transplant (OLT); **AND**
- Patient is receiving supplementation with vitamin A at the recommended daily allowance

† FDA Approved Indication(s); ‡ Compendium Recommended Indication(s)

IV. Renewal Criteria

Authorizations can be renewed based on the following criteria:

- Patient continues to meet the criteria identified in section III; **AND**
- Patient has a baseline urine protein to creatinine ratio (UPCR) of ≤ 1000 mg/g; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include the following: severe infusion-related reactions, stroke and cervicocephalic arterial dissection, hypovitaminosis A, severe thrombocytopenia, glomerulonephritis, hepatotoxicity, etc.; **AND**
- Disease response compared to pre-treatment baseline as evidenced by stabilization or improvement in one or more of the following:
  - Signs and symptoms of neuropathy
  - MRC muscle strength

V. Dosage/Administration

Indication	Dose
hATTR/ FAP polyneuropathy	The recommended dose of Tegsedi is 284 mg injected subcutaneously once weekly. • For consistency of dosing, patients should be instructed to give the injection on the same day every week. • If a dose is missed, patients should be instructed to take the missed dose as soon as possible, unless the next scheduled dose is within 2 days. In this situation, the patient should be directed to skip the missed dose and take the next scheduled dose on the scheduled day. • Patients should receive vitamin A supplementation.

VI. Billing Code/Availability Information

HCPCS code:

- J3490 – Unclassified Drugs

NDC:

- Tegsedi 284 mg/1.5 mL single-dose prefilled syringe: 71860-0007-xx

VII. References

1. Tegsedi [package insert]. Carlsbad, CA; Ionis Pharmaceuticals, Inc., October 2018. Accessed October 2018.
2. Benson MD, Waddington-Cruz M, Berk JL, et al. Inotersen Treatment for Patients with Hereditary Transthyretin Amyloidosis. N Engl J Med. 2018 Jul 5;379(1):22-31. doi: 10.1056/NEJMoa1716793.
3. Waddington-Cruz M, Ackermann EJ, Polydefkis M, H, et al. Hereditary transthyretin amyloidosis: baseline characteristics of patients in the NEURO-TTR trial. Amyloid. 2018 Aug 31:1-9. doi: 10.1080/13506129.2018.1503593.
4. Sekijima Y, Yoshida K, Tokuda T, et al. Familial Transthyretin Amyloidosis. Gene Reviews. Adam MP, Ardinger HH, Pagon RA, et al., editors. Seattle (WA): University of Washington, Seattle; 1993-2018.

Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
E85.1	Neuropathic heredofamilial amyloidosis

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: http://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx. Additional indications may be covered at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD): N/A

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
J (10)	TN, GA, AL	Cahaba Government Benefit Administrators, LLC
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA, LLC
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC