Tegsedi™ (inotersen)
(Subcutaneous)

Document Number: IC-0401

Last Review Date: 10/01/2021
Date of Origin: 10/30/2018
Dates Reviewed: 10/2018, 10/2019, 10/2020, 10/2021

I. Length of Authorization

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

II. Dosing Limits

A. Quantity Limit (max daily dose) [NDC Unit]:

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

B. Max Units (per dose and over time) [HCPCS Unit]:

- 284 mg every 7 days

III. Initial Approval Criteria [1]

Coverage is provided in the following conditions:

- Patient is at least 18 years of age; **AND**

Universal Criteria [1]

- 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 UPCR will be monitored every 2 weeks during treatment; **AND**
- Both the patient AND prescriber are enrolled in and meet the conditions of the Tegsedi REMS program; **AND**
- Patient is receiving supplementation with vitamin A at the recommended daily allowance; **AND**
- Must not be used in combination with other transthyretin (TTR) reducing agents (e.g., patisiran, tafamidis, etc.); **AND**

Polyneuropathy due to Hereditary Transthyretin-Mediated (hATTR) Amyloidosis /Familial Amyloidotic Polyneuropathy (FAP) † Φ [1-4,6]

- 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)

† FDA Approved Indication(s); ‡ Compendium Recommended Indication(s); Φ Orphan Drug

IV. Renewal Criteria [1-4.6]

Coverage can be renewed based upon the following criteria:

- Patient continues to meet the universal and indication specific criteria identified in section III; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: stroke and cervicocephalic arterial dissection, ocular symptoms related to hypovitaminosis A, severe thrombocytopenia, glomerulonephritis and renal toxicity, hepatotoxicity, serious inflammatory and immune reactions, hypersensitivity reactions/antibody formation, 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 [1]

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.

VI. Billing Code/Availability Information

HCPCS code:

- J3490 – Unclassified drugs
- C9399 – Unclassified drugs or biologicals *(Hospital Outpatient Use Only)*

NDC:

- Tegsedi 284 mg/1.5 mL single-dose prefilled syringe: 72126-0007-xx

VII. References

1. Tegsedi [package insert]. Waltham, MA; Sobi, Inc., May 2021. Accessed August 2021.
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.
5. Ando Y, Coelho T, Berk JL, et al. Guideline of transthyretin-related hereditary amyloidosis for clinicians. Orphanet J Rare Dis. 2013;8:31.
6. Sekijima Y. Hereditary Transthyretin Amyloidosis. 2001 Nov 5 [updated 2021 Jun 17]. In: Adam MP, Ardinger HH, Pagon RA, Wallace SE, Bean LJH, Mirzaa G, Amemiya A, editors. GeneReviews® [Internet]. Seattle (WA): University of Washington, Seattle; 1993–2021.

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), Local Coverage Articles (LCAs), 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/LCA/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.
J (10)	TN, GA, AL	Palmetto GBA, 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