Vyndamax™ (tafamidis)
Vyndaqel® (tafamidis meglumine)
(Oral)

Last Review Date: 10/01/2020
Date of Origin: 07/01/2019
Dates Reviewed: 07/2019, 10/2019, 10/2020

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]:
   - Vyndaqel 20 mg capsule: 4 capsules per day
   - Vyndamax 61 mg capsule: 1 capsule per day

B. Max Units (per dose and over time) [HCPCS Unit]:
   - Vyndaqel: 80mg daily
   - Vyndamax: 61 mg daily

III. Initial Approval Criteria

Coverage is provided in the following conditions:

- Patient must be at least 18 years old: AND

Universal Criteria

- Must not be used in combination with other transthyretin (TTR) reducing agents (e.g., inotersen, patisiran, etc.): AND
- Patient has New York Heart Association (NYHA) class I or II heart failure (i.e., excludes patients with NYHA Class III and IV disease): AND
- Patient does not have primary (light chain) amyloidosis: AND
- Patient has not had a prior liver transplant: AND
- Patient does not have an implanted cardiac mechanical-assist device (e.g., left-ventricular assist device, etc.): AND
Cardiomyopathy of Wild Type Transthyretin-Mediated Amyloidosis (ATTR-CM)\* † Φ \(^{1-6}\)

- Patient has evidence of cardiac involvement by echocardiography with an end-diastolic interventricular septal wall thickness > 12 mm; **AND**
- Patient has a definitive diagnosis of ATTR amyloidosis as documented by amyloid deposition on tissue biopsy and identification of a pathogenic TTR variant and/or TTR precursor using molecular genetic testing (i.e., immunohistochemistry, scintigraphy or mass spectrometry); **AND**
  - Patient has a medical of heart failure which required at least 1 prior hospitalization: **OR**
  - Patient has clinical evidence of heart failure, without a prior history of hospitalization for disease, manifested by signs or symptoms of volume overload or elevated intracardiac pressure (e.g., elevated jugular venous pressure, shortness of breath or signs of pulmonary congestion on x-ray or auscultation, peripheral edema) which requires/required treatment with a diuretic: **AND**
- Patient has a baseline 6-minute walk-test distance exceeding 100 m

\*Note: Requests for patients with hereditary transthyretin-mediated amyloidosis (ATTR-m) genotype and/or NYHA Class III disease will be reviewed on a case-by-case basis.

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

IV. Renewal Criteria \(^{1,2,4,5}\)

Authorizations can be renewed based on the following criteria:

- Patient continues to meet the universal and other indication specific relevant criteria identified in section III; **AND**
- Absence of unacceptable toxicity from the drug; **AND**
  - Disease response compared to pre-treatment baseline as evidenced by decreased frequency of cardiovascular-related hospitalizations, defined as the number of times a patient was hospitalized (i.e., admitted to a hospital) for cardiovascular-related morbidity: **OR**
  - Patient has had an improvement in the in the total distance walked during 6-Minute Walk Test (6MWT) as compared to baseline

V. Dosage/Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dose</th>
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<tbody>
<tr>
<td>ATTR cardiomyopathy</td>
<td><strong>Vyndaqel</strong></td>
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<tr>
<td></td>
<td>- The recommended dosage is VYNDAQEL 80 mg (four 20-mg tafamidis meglumine capsules) orally once daily.</td>
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<tr>
<td><strong>Vyndamax</strong></td>
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VI. Billing Code/Availability Information

HCPCS code:
- J8499 – Prescription drug, oral, non chemotherapeutic, nos

NDC:
- Vyndaqel 20 mg capsules: 00069-1975-xx
- Vyndamax 61 mg capsules: 00069-8730-xx

VII. References


Appendix 1 – Covered Diagnosis Codes

<table>
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<tr>
<th>ICD-10</th>
<th>ICD-10 Description</th>
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<tbody>
<tr>
<td>E85.82</td>
<td>Wild-type transthyretin-related (ATTR) amyloidosis</td>
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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

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</tr>
<tr>
<td>F (2 &amp; 3)</td>
<td>AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ</td>
<td>Noridian Healthcare Solutions, LLC</td>
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<tr>
<td>5</td>
<td>KS, NE, IA, MO</td>
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<tr>
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<tr>
<td>M (11)</td>
<td>NC, SC, WV, VA (excluding below)</td>
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</tr>
<tr>
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<td>Novitas Solutions, Inc.</td>
</tr>
<tr>
<td>K (13 &amp; 14)</td>
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