

Medical Policy:

Amondys 45™ (casimersen) intravenous infusion

POLICY NUMBER	LAST REVIEW	ORIGIN DATE
MG.MM.PH.331	March 26, 2025	June 9, 2021

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The treating physician or primary care provider must submit to EmblemHealth, or ConnectiCare, as applicable (hereinafter jointly referred to as “EmblemHealth”), the clinical evidence that the member meets the criteria for the treatment or surgical procedure. Without this documentation and information, EmblemHealth will not be able to properly review the request preauthorization or post-payment review. The clinical review criteria expressed below reflects how EmblemHealth determines whether certain services or supplies are medically necessary. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. Health care providers are expected to exercise their medical judgment in rendering appropriate care.

EmblemHealth established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). EmblemHealth expressly reserves the right to revise these conclusions as clinical information changes and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by EmblemHealth, as some programs exclude coverage for services or supplies that EmblemHealth considers medically necessary.

If there is a discrepancy between this guideline and a member's benefits program, the benefits program will govern. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and web site links are accurate at time of publication.

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Definitions

Amondys 45 is an antisense oligonucleotide 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. These patients represent up to 8% of all patients with DMD. This genetic manipulation intends to restore the reading frame of the resulting mRNA. The result would be production of a shortened, but partially functional dystrophin protein as seen in less severe forms of muscular dystrophy (e.g., Becker muscular dystrophy).

Length of Authorization

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

Dosing Limits [Medical Benefit]

The recommended dosage is 30mg/kg as an intravenous infusion over approximately 35 to 60 minutes once weekly.

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

- 350 billable units (3500 mg) every 7 days

Guideline

I. INITIAL APPROVAL CRITERIA

Coverage will be provided when the following criteria are met:

1. Duchenne muscular dystrophy (DMD)

- A. Patient has a diagnosis of Duchenne Muscular Dystrophy (DMD) confirmed by genetic testing; **AND**
- B. Specific type of DMD gene mutation which amenable to exon 45 skipping has been confirmed; **AND**
- C. Patient retains meaningful voluntary motor function (e.g., patient is able to speak, manipulate objects using upper extremities, ambulate, etc.); **AND**
- D. Patient is receiving physical and/or occupational therapy; **AND**
- E. Baseline documentation of **ONE or more** of the following:
 - i. Dystrophin level
 - ii. Timed function tests (e.g., 6-minute walk test [6MWT], time to stand [TTSTAND], time to run/walk 10 meters [TTRW], time to climb 4 stairs [TTCLIMB], etc.)
 - iii. Upper limb function (ULM) test
 - iv. North Star Ambulatory Assessment (NSAA) score
 - v. Forced Vital Capacity (FVC) percent predicted
- F. Patient has been on a stable dose of corticosteroids for at least 6 months (unless contraindicated or intolerance); **AND**
- G. Prescribing provider is a neurologist or DMD specialist

II. RENEWAL APPROVAL CRITERIA

Coverage can be renewed for six months based on the following conditions:

- A. Stabilization of disease or absence of disease progression; **AND**
- B. Absence of unacceptable toxicity from the drug.
- C. Patient has responded to therapy compared to pretreatment baseline in **one or more** of the following (not all-inclusive):
 - i. Increase in dystrophin level
 - ii. Improvement in quality of life
 - iii. Stability, improvement, or slowed rate of decline in one or more of the following:
 - a. Timed function tests (e.g., 6-minute walk test [6MWT], time to stand [TTSTAND], time to run/walk 10 meters [TTRW], time to climb 4 stairs [TTCLIMB], etc.)
 - b. Upper limb function (ULM) test
 - c. North Star Ambulatory Assessment (NSAA) score
 - d. Forced Vital Capacity FVC percent predicted

Limitations:

- 1. Patient is not on concomitant therapy with other DMD-directed antisense oligonucleotides (e.g., eteplirsen, golodirsen, viltolarsen, etc.); **AND**
- 2. Serum cystatin C, urine dipstick, and urine protein-to-creatinine ratio (UPCR) are measured prior to starting therapy and periodically during treatment.

Applicable Procedure Codes

Code	Description
J1426	Injection, casimersen, 10 mg

Applicable NDCs

Code	Description
60923-0227-02	Injection, 100 mg/2 mL (50 mg/ mL) solution in a single-dose vial

ICD-10 Diagnoses

Code	Description
G71.01	Duchenne or Becker Muscular Dystrophy

Revision History

Company(ies)	DATE	REVISION
EmblemHealth & ConnectiCare	3/26/2025	Annual Review: Addition of limitation criteria added.
EmblemHealth & ConnectiCare	4/22/2024	Annual Review: Updated dosing limits, no criteria changes.
EmblemHealth & ConnectiCare	8/8/2023	Annual Review: <u>Duchenne muscular dystrophy (DMD) Initial Criteria:</u> Removed "Patient must be ambulatory (e.g. 6-minute walk test (6MWT) greater than or equal to 300 meters while walking independently, North star Ambulatory Assessment (NSAA) score of greater than 17, or achieved rise time (Gower's test) less than 7 seconds); AND " Added "Patient retains meaningful voluntary motor function (e.g., patient is able to speak, manipulate objects using upper extremities, ambulate, etc.); AND Patient is receiving physical and/or occupational therapy; AND Baseline documentation of one or more of the following: i. Dystrophin level ii. Timed function tests (e.g., 6-minute walk test [6MWT], time to stand [TTSTAND], time to run/walk 10 meters [TTRW], time to climb 4 stairs [TTCLIMB], etc.) iii. Upper limb function (ULM) test iv. North Star Ambulatory Assessment (NSAA) score v. Forced Vital Capacity (FVC) percent predicted" <u>Renewal Criteria:</u> Added "Patient has responded to therapy compared to pretreatment baseline in one or more of the following (not all-inclusive): i. Increase in dystrophin level ii. Improvement in quality of life iii. Stability, improvement, or slowed rate of decline in one or more of the following: a. Timed function tests (e.g., 6-minute walk test [6MWT], time to stand [TTSTAND], time to run/walk 10 meters [TTRW], time to climb 4 stairs [TTCLIMB], etc.) b. Upper limb function (ULM) test c. North Star Ambulatory Assessment (NSAA) score d. Forced Vital Capacity FVC percent predicted"
EmblemHealth & ConnectiCare	3/23/2022	Updated Procedure Code to J1426 and put on new template
EmblemHealth & ConnectiCare	6/9/2021	New Policy – went to 2Q2021 P&T, June 9, 2021

References

1. Amondys 45 intravenous Injection [package insert]. Cambridge, MA. Sarepta Therapeutics, Inc. Updated February 25, 2021. Accessed March 26, 2021. Available at: <https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=e9e5fd44-eeda-4580-bba1-a734828bbcc3>.
2. Amondys 45 intravenous Injection. IBM Micromedex® [database online]. Greenwood Village, CO. Truven Health Analytics. Available at: <https://www.micromedexsolutions.com>. Updated March 8, 2021. Accessed March 26, 2021.
3. CureDuchenne [Web site]. Available at: <https://www.cureduchenne.org/>.
4. Birnkrant DJ, Bushby K, Bann CM, et al. Diagnosis and management of Duchenne muscular dystrophy, part 1: diagnosis, and neuromuscular, rehabilitation, endocrine, and gastrointestinal and nutritional management. *Lancet Neurol*. 2018;17(3):251-267.
5. Shimizu-Motohashi Y, Murakami T, Kimura E, et al. Exon skipping for Duchenne muscular dystrophy: a systematic review and meta-analysis. *Orphanet J Rare Dis*. 2018;13(1):93.