MEDICAL MUTUAL®

Drug Policy

Policy:	**220701**	**Initial Effective Date: 08/26/2022**
Code(s):	**HCPCS J3490, or C9399**	**Annual Review Date: 07/17/2024**
SUBJECT:	**Amvuttra ® (vutrisiran)**	**Last Revised Date: 07/17/2024**

☒Subject to Site of Care

Prior approval is required for some or all procedure codes listed in this Corporate Drug Policy.

Initial and renewal requests for the medication(s) listed in this policy are subject to site of care management. When billed under the medical benefit, administration of the medication will be restricted to a non-hospital facility-based location (i.e., home infusion provider, provider's office, free-standing ambulatory infusion center) unless the member meets the site of care exception criteria. To view the exception criteria and a list of medications subject to site of care management please click here.

I. Length of Authorization

Initial coverage will be provided for 6 months and may be renewed annually thereafter.

II. Dosing Limits

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

- Amvuttra 25 mg/0.5 mL single-dose prefilled syringe: 1 syringe every 3 months

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

- 25 billable units (25 mg) every 3 months

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 is receiving supplementation with vitamin A at the recommended daily allowance; **AND**
- Must not be used in combination with other transthyretin (TTR) reducing or stabilizing agents (e.g., inotersen, tafamidis, patisiran, etc.); **AND**

Polyneuropathy due to Hereditary Transthyretin-Mediated (hATTR) Amyloidosis † Φ [1,5-8]

- Patient has a definitive diagnosis of hATTR amyloidosis as documented in a heterozygous pathogenic (or likely pathogenic) variant in *TTR* identified by 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 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 [1,5-8]

Coverage can be renewed based upon 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. Examples of unacceptable toxicity include: ocular symptoms related to vitamin A deficiency (e.g., night blindness), 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 polyneuropathy	• The recommended dosage of Amvuttra is 25 mg administered by subcutaneous injection once every 3 months. • ***Note:*** Amvuttra should be administered by a healthcare professional.

VI. Billing Code/Availability Information

HCPCS Code:

- J0225 – Injection, vutrisiran, 1 mg; 1 billable unit = 1 mg

NDC:

- Amvuttra 25 mg/0.5 mL single-dose prefilled syringe: 71336-1003-xx

VII. References

1. Amvuttra [package insert]. Cambridge, MA; Alnylam Pharmaceuticals, Inc., February 2023. Accessed May 2024.
2. Adams D, Gonzalez-Duarte A, O'Riordan WD, et al. Patisiran, an RNAi Therapeutic, for Hereditary Transthyretin Amyloidosis. N Engl J Med. 2018 Jul 5;379(1):11-21. doi: 10.1056/NEJMoa1716153
3. Adams D, Suhr OB, Dyck PJ, et al. Trial design and rationale for APOLLO, a Phase 3, placebo-controlled study of patisiran in patients with hereditary ATTR amyloidosis with polyneuropathy. BMC Neurol. 2017;17(1):181
4. Ando Y, Coelho T, Berk JL, et al. Guideline of transthyretin-related hereditary amyloidosis for clinicians. Orphanet J Rare Dis. 2013;8:31.
5. Sekijima Y, Nakamura K. Hereditary Transthyretin Amyloidosis. In: Adam MP, Feldman J, Mirzaa G, et al., editors. GeneReviews® [Internet]. Seattle (WA): University of Washington, Seattle; 1993–2024. Initial Posting: November 5, 2001; Last Update: May 30, 2024. Accessed June 11, 2024. https://www.ncbi.nlm.nih.gov/books/NBK1194/.
6. Luigetti M, Romano A, DiPaolantonio A, et al. Diagnosis and Treatment of Hereditary Transthyretin Amyloidosis (hATTR) Polyneuropathy: Current Perspectives on Improving Patient Care. Ther Clin Risk Manag. 2020; 16: 109–123.Published online 2020 Feb 21. doi: 10.2147/TCRM.S219979
7. Gonzalez-Duarte A, Adams D, Tournev I, et al. HELIOS-A: results from the phase 3 study of vutrisiran in patients with hereditary transthyretin-mediated amyloidosis with polyneuropathy. *J Am Coll Cardiol.* 2022 Mar, 79 (9_Supplement) 302. https://doi.org/10.1016/S0735-1097(22)01293-1.
8. Adams D, Tournev IL, Taylor MS, et al; HELIOS-A Collaborators. Efficacy and safety of vutrisiran for patients with hereditary transthyretin-mediated amyloidosis with polyneuropathy: a randomized clinical trial. Amyloid. 2023 Mar;30(1):1-9. doi: 10.1080/13506129.2022.2091985. Epub 2022 Jul 23. PMID: 35875890.

Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the drug provided or services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

FOR MEDICAL BENEFIT COVERAGE REQUESTS:

Prior approval is required for HCPCS Codes J3490, C9399

†**When *unclassified drugs or unclassified drugs and biologicials* (J3490, C9399) is determined to be Amvuttra**

Edits and Denials:

Prior approval: Prior approval is required for Amvuttra **(HCPCS Codes J3490, C9399)**. Requests for prior approval will be authorized by a nurse reviewer if submitted documentation meets criteria outlined within the Corporate Medical Policy.

Requests for prior approval will be forwarded to a qualified physician reviewer if submitted documentation does not meet criteria outlined within Corporate Medical Policy.

TOPPS: Claims received with **HCPCS Codes J3490 or C9399** will pend with **Remark Code M3M or M4M** and will be adjudicated in accordance with the Corporate Medical Policy.

Liability: A participating provider will be required to write off charges denied as not medically necessary.

HCPCS Code(s):	
J0225	Injection, vutrisiran, 1 mg: 1 billable unit = 1 mg