MEDICAL MUTUAL®

Drug Policy

Policy:	**240201**	**Initial Effective Date: 02/20/2024**
Code(s):	**HCPCS J3490, J3590**	**Annual Review Date: 02/20/2025**
SUBJECT:	**Wainua (**eplontersen subcutaneous injection**)**	**Last Revised Date: 02/20/2025**

Subject to: ☐Site of Care
☐Medication Sourcing

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

OVERVIEW

Wainua, a transthyretin (TTR)-directed antisense oligonucleotide, is indicated for the treatment of the **polyneuropathy of hereditary transthyretin-mediated amyloidosis (hATTR)** in adults.

POLICY STATEMENT

This policy involves the use of Wainua. Prior authorization is recommended for pharmacy and medical benefit coverage of Wainua. Approval is recommended for those who meet the conditions of coverage in the **Criteria, Dosing, Initial/Extended Approval,** and **Duration of Therapy** for the diagnosis provided. **Waste Management** applies for all covered conditions that are administered by a healthcare professional. **Conditions Not Recommended for Approval** are listed following the recommended authorization criteria and Waste Management section. Requests for uses not listed in this policy will be reviewed for evidence of efficacy and for medical necessity on a case-by-case basis.

Because of the specialized skills required for evaluation and diagnosis of patients treated with Wainua as well as the monitoring required for AEs and long-term efficacy, initial approval requires Wainua be prescribed by or in consultation with a physician who specializes in the condition being treated. All approvals for initial therapy are provided for the initial approval duration noted below; if reauthorization is allowed, a response to therapy is required for continuation of therapy unless otherwise noted below.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Wainua is recommended in those who meet the following criteria:

1. **Polyneuropathy of Hereditary Transthyretin-Mediated Amyloidosis (hATTR).** Approve if the patient meets ALL of the following (A, B, C, D, and E):
   - **A)** Patient is ≥18 years of age; AND
   - **B)** Patient has a transthyretin mutation as confirmed by genetic testing [documentation required]; AND
   - **C)** Presence of polyneuropathy characterized by ONE of the following (i, ii, or iii) [documentation requirement];
     i. Baseline Neuropathy Impairment Scale+7 (mNIS+7) OR;

ii. Baseline Norfolk Quality of Life Diabetic Neuropathy (QoL-DN) Questionnaire OR;
iii. Baseline FAP Stage 1 or 2 AND;

D) Patient has polyneuropathy as demonstrated by at least TWO of the following criteria (i, ii, or iii):
i. Subjective patient symptoms are suggestive of neuropathy
ii. Abnormal nerve conduction studies are consistent with polyneuropathy
iii. Abnormal neurological examination is suggestive of neuropathy; AND

E) Patient's peripheral neuropathy is attributed to hATTR/FAP and other causes of neuropathy have been excluded; AND

F) The requested medication will not be used concurrently with Onpattro (patisiran) injections, Amvuttra (vutrisiran) injections, or tafamadis products (Vynaqel and Vyndamax); AND

G) Patient does not have a history of liver transplantation; AND

H) The medication is prescribed by or in consultation with a neurologist, geneticist, or a physician who specializes in the treatment of amyloidosis.

Continuation of therapy, *Patient must meet all of the following* (A, B, C, D

A) Patient is ≥18 years of age; AND

B) Patient has experienced a positive clinical response to Wainua (e.g., improved neurologic impairment, motor function, cardiac function, quality of life assessment, serum TTR levels, etc.); AND

C) Improvement from baseline or stabilization of ONE of the following (i, ii, or iii)
i. Baseline Neuropathy Impairment Scale+7 (mNIS+7)
ii. Baseline Norfolk Quality of Life Diabetic Neuropathy (QoL-DN) Questionnaire
iii. Baseline FAP Stage 1 or 2

D) The requested medication will not be used concurrently with Onpattro (patisiran) injections, Amvuttra (vutrisiran) injections, Tegsedi (inotersen) injections or tafamadis products (Vynaqel and Vyndamax); AND

E) Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: ocular symptoms related to hypovitaminosis A, etc.; AND

F) The medication is prescribed by or in consultation with a neurologist, geneticist, or a physician who specializes in the treatment of amyloidosis.

Dosing in hATTR. *Dosing must meet the following:*

- 45mg subcutaneously once monthly

Initial Approval/ Extended Approval.
A) *Initial Approval:6 months*
B) *Extended Approval: 1 year*

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Wainua has not been shown to be effective, or there are limited or preliminary data or potential safety concerns that are not supportive of general approval for the following conditions. (Note: This is not an exhaustive list of Conditions Not Recommended for Approval).

1. **Concomitant Use With Amvuttra (vutrisiran subcutaneous injection), Onpattro (patisiran intravenous infusion), Tegsedi (inotersen subcutaneous injection), or a Tafamidis Product.**
   Note: Examples of tafamidis products are Vyndaqel and Vyndamax.
   There are insufficient data supporting the safety and efficacy of concurrent use of these agents for hereditary transthyretin-mediated amyloidosis with polyneuropathy. The Vyndaqel/Vyndamax pivotal trial, which took place prior to when Onpattro and Tegsedi were under investigation for amyloidosis, did not include patients who were taking investigational drugs. The pivotal trials for Amvuttra, Onpattro, Tegsedi, and Wainua did not allow concurrent use of tetramer stabilizers (e.g., tafamidis, diflunisal). A Phase II open-label extension study (n = 27) included 13 patients who were treated concomitantly with Onpattro and tafamidis.[5] Following 24 months of treatment, there was no significant difference in the median serum transthyretin percent change from baseline with concomitant Onpattro and tafamidis (-80%) vs. Onpattro monotherapy (-88%). A scientific statement from the AHA notes that there is little data to support combination therapy for these products.[3]

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.

REFERENCES

1. Wainua™ subcutaneous injection [prescribing information]. Wilmington, DE: AstraZeneca; December 2023.
2. Alcantara M, Mezi MM, Baker SK, et al. Canadian guidelines for hereditary transthyretin amyloidosis polyneuropathy management. *Can J Nero Sci.* 2022;49:7-18.
3. Kittleson MM, Maurer MS, Ambardekar AV, et al; on behalf of the American Heart Association Heart Failure and Transplantation Committee of the Council on Clinical Cardiology. AHA scientific statement: cardiac amyloidosis: evolving diagnosis and management. *Circulation.* 2020;142:e7-e22.
4. McDonagh TA, Metra M, Adamo M, et al. 2021 ESC guidelines for the diagnosis and treatment of acute and chronic heart failure. *Eur Heart J.* 2021;42:3599-3726.
5. Lin H, Merkel M, Hale C, Marantz JL. Experience of patisiran with transthyretin stabilizers in patients with hereditary transthyretin-mediated amyloidosis. *Neurodegener Dis Manag*. 2020;10(5):289-300.
6. Coelho T, Ando Y, Benson MD, et al. Design and rationale of the global Phase 3 NEURO-TTransform Study of antisense oligonucleotide AKCEA-TTR-L_{rx} (ION-682884-CS3) in hereditary transthyretin-mediated amyloid polyneuropathy. *Neurol Ther.* 2021;10:375-389.

FOR MEDICAL BENEFIT COVERAGE REQUESTS:

Prior approval is required for HCPCS Codes J3490 and J3590

MEDICAL MUTUAL®

Drug
Policy

†When *unclassified drugs* (J3490) or *unclassified biologics* (J3590) or *unclassified* is determined to be Wainua

Edits and Denials:

Prior approval: Prior approval is required for Wainua **(HCPCS Codes J3490, J3590)**. 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.

HCPCS Code(s):	
J3490	Unclassified drugs
J3590	Unclassified biologics