Medical Necessity Guidelines: 
Amyloidosis Therapies: Amvuttra™ (vutrisiran) and Onpattro® (patisiran)

Effective: January 1, 2023

Prior Authorization Required
If REQUIRED, submit supporting clinical documentation pertinent to service request.

<table>
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<th>Applies to:</th>
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<tr>
<td>Commercial Products</td>
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<tr>
<td>☒ Harvard Pilgrim Health Care Commercial products; Fax 617-673-0988</td>
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<tr>
<td>☒ Tufts Health Plan Commercial products; Fax 617-673-0988</td>
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<tr>
<td>CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization</td>
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<tr>
<td>☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax 617-673-0988</td>
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<tr>
<td>☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax 617-673-0988</td>
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<td>☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax 617-673-0988</td>
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<tr>
<td>☐ Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax 617-673-0956</td>
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<tr>
<td>☒ Tufts Medicare Preferred HMO, (a Medicare Advantage product); Fax 617-673-0956</td>
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<tr>
<td>☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); Fax 617-673-0956</td>
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<tr>
<td>☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); Fax 617-673-0956</td>
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<tr>
<td>☐ Harvard Pilgrim Health Care Stride Medicare Advantage; Fax 617-673-0956</td>
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<tr>
<td>☐ Tufts Medicare Preferred MCO, (a Medicare Advantage product); Fax 617-673-0956</td>
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Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Food and Drug Administration (FDA) Approved Indications:
- Amvuttra (vutrisiran) is a transthyretin-directed small interfering RNA indicated for the treatment of the polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults.
- Onpattro (patisiran) contains a transthyretin-directed small interfering RNA and is indicated for the treatment of polyneuropathy of hereditary transthyretin-mediated amyloidosis (ATTR-FAP) in adults.

Clinical Guideline Coverage Criteria

Initial Authorization Criteria
The Plan may authorize 12 months of initial coverage with Amvuttra (vutrisiran) and Onpattro (patisiran) for Members when all the following criteria are met:
1. The Member has a documented diagnosis of polyneuropathy of hereditary transthyretin-mediated amyloidosis that has been confirmed by detection of a mutation of the TTR gene.
2. Member exhibits clinical manifestations of ATTR-FAP (transthyretin-type familial amyloid polyneuropathy), e.g., amyloid deposition in biopsy specimens, TTR protein variants in serum, progressive peripheral sensory-motor polyneuropathy.
3. Prescribed by or in consultation with a neurologist or physician specializing in the treatment of amyloidosis.
4. The Member has a documented baseline Polyneuropathy Disability (PND) score of IIIb or lower
   a. Stage I: Walking
b. Stage II: Impaired walking but without the need for a stick or crutch

c. Stage IIIa: Walking with one stick or crutch

d. Stage IIIb: Walking with two sticks or crutches

5. The Member is at least 18 years of age

6. The member has not had a prior liver transplant

**Reauthorization Criteria**

The Plan may reauthorize 12 months intervals of coverage with Amvuttra (vutrisiran) and Onpattro (patisiran) for Members when all the following criteria are met:

1. The Member must have met all initial authorization criteria as noted above.

2. The Member must have demonstrated a beneficial response to treatment with the requested therapy compared to baseline (e.g., improvement of neuropathy severity and rate of disease progression as demonstrated by the modified Neuropathy Impairment Scale+7 (mNIS+7) composite score, the Norfolk Quality of Life- Diabetic Neuropathy (QoL-DN) total score, polynuropathy disability (PND) score, FAP disease stage, manual grip strength).

3. The Member has not had a prior liver transplant

4. The Member has a Polyneuropathy Disability (PND) score of IIIb or lower:
   
   I. Stage I: Walking
   
   II. Stage II: Impaired walking but without the need for a stick or crutch Stage IIIa: Walking with the help of one stick or crutch
   
   III. Stage IIIb: Walking with the help of two sticks or crutches
   
   IV. Stage IV: Confined to a wheelchair or bedridden

**Limitations**

- Initial approval of hereditary amyloidosis products will be given in 12-month intervals. Subsequent authorization requests may be given in 12-month intervals when Reauthorization criteria above have been met.
- Members new to the plan stable on treatment with a hereditary amyloidosis product must meet Initial Authorization criteria if on treatment for less than a year and must meet Reauthorization criteria if on treatment for more than a year.
- Combination hereditary amyloidosis product therapy will not be authorized.
- Treatment of sensorimotor or autonomic neuropathy not related to hereditary transthyretin-mediated amyloidosis will not be approved.

**Codes**

The following code(s) require prior authorization:

**Table 1: HCPCS Codes**

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<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>J0222</td>
<td>Injection, patisiran, 0.1 mg</td>
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<tr>
<td>J0225</td>
<td>Injection, vutrisiran, 1 mg</td>
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**References:**


Abstract P1.324.


Approval And Revision History

September 13, 2022: Reviewed by Pharmacy and Therapeutics Committee (P&T)
September 21, 2022: Reviewed by the Medical Policy Approval Committee (MPAC)
Subsequent endorsement date(s) and changes made:
• December 22, 2022: Administrative update: Amvuttra code J0225 added, effective January 1, 2023

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.