Clinical Policy: Patisiran (Onpattro)

Reference Number: LA.PHAR.395
Effective Date:
Last Review Date: 06.26.23
Line of Business: Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

****Please note: This policy is for medical benefit****

Description

Patisiran (Onpattro™) is a transthyretin (TTR)-directed small interfering ribonucleic acid.

FDA Approved Indication(s)

Onpattro is indicated for the treatment of the polyneuropathy of hereditary TTR-mediated amyloidosis in adults.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of Louisiana Healthcare Connections® that Onpattro is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Hereditary Transthyretin-Mediated Amyloidosis (must meet all)**:**

1. Diagnosis of hereditary TTR-mediated amyloidosis with polyneuropathy;
2. Documentation confirms presence of a TTR mutation;
3. Biopsy is positive for amyloid deposits or medical justification is provided as to why treatment should be initiated despite a negative biopsy or no biopsy;
4. Prescribed by or in consultation with a neurologist;
5. Age ≥ 18 years;
6. Member has not had a prior liver transplant;
7. Member has not received prior treatment with Amvuttra™ or Tegsedi™;
8. Onpattro is not prescribed concurrently with Amvuttra or Tegsedi;
9. Dose does not exceed the following (based on actual body weight):
   a. Weight < 100 kg: 0.3 mg/kg once every 3 weeks;
   b. Weight ≥ 100 kg: 30 mg once every 3 weeks.

Approval duration: 6 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy LA.PMN.53

II. Continued Therapy

A. Hereditary Transthyretin-Mediated Amyloidosis (must meet all)**:**

1. Currently receiving medication via Louisiana Healthcare Connections benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy [e.g., improved measures of polyneuropathy (e.g., motor strength, sensation, and reflexes), improvement in quality of life, motor function, walking ability (e.g., as measured by timed 10-m walk test), and nutritional status (e.g., as evaluated by modified mass index)];
3. Member has not had a prior liver transplant;
4. Onpattro is not prescribed concurrently with Amvuttra or Tegsedi;
5. If request is for a dose increase, new dose does not exceed the following (based on actual body weight):
   a. Weight < 100 kg: 0.3 mg/kg once every 3 weeks;
   b. Weight ≥ 100 kg: 30 mg once every 3 weeks.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy LA.PMN.53

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy LA.PMN.53

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
TTR: transthyretin

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings
None reported

Appendix D: General Information

- To confirm amyloidosis, the demonstration of amyloid deposits via tissue biopsy is essential. Deposition of amyloid in the tissue can be demonstrated by Congo red staining of biopsy specimens. With Congo red staining, amyloid deposits show a characteristic green birefringence under polarized light; however, negative biopsy results should not be interpreted as excluding the disease.
- DNA sequencing is usually required for genetic confirmation. Current techniques for performing sequence analysis of TTR, the only gene known to be associated with TTR amyloidosis, detect > 99% of disease-causing mutations.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Hereditary TTR-mediated amyloidosis-associated polyneuropathy	• Adults weighing < 100 kg: 0.3 mg/kg IV every 3 weeks • Adults weighing ≥ 100 kg: 30 mg IV every 3 weeks • Premedicate with a corticosteroid, acetaminophen, and antihistamines to reduce the risk of infusion-related reactions. • Onpattro should be administered by a healthcare professional.	See dosing regimen

VI. Product Availability

Lipid complex injection (single-dose vial): 10 mg/5 mL (2 mg/mL)

VII. References

1. Onpattro Prescribing Information. Cambridge, MA: Alnylam Pharmaceuticals, Inc.; July 2022. Available at: https://www.alnylam.com/sites/default/files/pdfs/ONPATTRO-Prescribing-Information.pdf. Accessed August 1, 2022.
2. Ando Y, Coelho T, Berk JL, et al. Guideline of transthyretin-related hereditary amyloidosis for clinicians. Orphanet J Rare Dis. 2013 Feb 20;8:31.
3. 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.
4. Magrinelli F, Fabrizi GM, Santoro L, et al. Pharmacological treatment for familial amyloid polyneuropathy. Cochrane Database Syst Rev. 2020;4(4):CD012395.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J0222	Injection, patisiran, 0.1 mg

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Converted corporate policy to local policy	06.26.23	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developingthis clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.