

## Medical Policy: Onpattro® (patisiran) Intravenous

POLICY NUMBER	LAST REVIEW	ORIGIN DATE
MG.MM.PH.119	January 31, 2024	

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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.

EmblemHealth may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice. EmblemHealth Services Company, LLC, has adopted this policy in providing management, administrative and other services to EmblemHealth Plan, Inc., EmblemHealth Insurance Company, EmblemHealth Services Company, LLC, and Health Insurance Plan of Greater New York (HIP) related to health benefit plans offered by these entities. ConnectiCare, an EmblemHealth company, has also adopted this policy. All of the aforementioned entities are affiliated companies under common control of EmblemHealth Inc.

### Definitions

Patisiran was FDA approved for the treatment of the polyneuropathy of hATTR amyloidosis in adults. hATTR amyloidosis is a rapidly progressive, life-threatening disease caused by mutant and wild-type transthyretin (TTR) proteins forming amyloid deposits in tissues throughout the body. More than 95% of TTR circulating in the body is produced by the liver. This amyloid accumulation leads to progressive multisystem dysfunction, including polyneuropathy (e.g., sensorimotor and autonomic neuropathy) and cardiomyopathy. Patisiran is a double-stranded small interfering ribonucleic acid (siRNA) formulated as a lipid nanoparticle complex for delivery to hepatocytes. Patisiran causes the degradation of mutant and wild-type TTR mRNA through RNA interference, which results in a reduction of serum TTR protein and TTR protein deposits in tissues.

### Length of Authorization

Initial: Coverage will be provided for 6 months

Renewal: Coverage will be provided for 12 months

### Dosing Limits [Medical Benefit]

**Max Units (per dose and over time):**

- 30 mg every 3 weeks (300 billable units every 3 weeks)

## Guideline

### I. Initial Approval Criteria

***Patisiran** may be considered medically necessary if one of the below conditions are met **AND** use is consistent with the medical necessity criteria that follows:*

**Polyneuropathy of hATTR amyloidosis (hATTR)/Familial Amyloidotic Polyneuropathy (FAP)†**

1. Patient must be at least 18 years old; **AND**
2. Patient has a definitive diagnosis of hATTR amyloidosis/FAP as documented by identification of a pathogenic TTR variant using molecular genetic testing; **AND**
3. Used for the treatment of polyneuropathy as demonstrated by at least **TWO** of the following criteria:
  - a. Subjective patient symptoms are suggestive of neuropathy
  - b. Abnormal nerve conduction studies are consistent with polyneuropathy
  - c. Abnormal neurological examination is suggestive of neuropathy; **AND**
4. Patient’s peripheral neuropathy is attributed to hATTR/FAP and other causes of neuropathy have been excluded; **AND**
5. Baseline in strength/weakness has been documented using an objective clinical measuring tool (e.g., Medical Research Council (MRC) muscle strength, etc.); **AND**
6. Patient has not been the recipient of an orthotopic liver transplant (OLT); **AND**
7. Patient is receiving supplementation with vitamin A at the recommended daily allowance

† FDA-labeled indication(s);

### Limitations/Exclusions

1. Onpattro is not considered medically necessary for indications other than those listed above due to insufficient evidence of therapeutic value.
2. Concomitant Use With Amvuttra (vutrisiran subcutaneous injection), Tegsedi (inotersen subcutaneous injection), Wainua (eplontersen subcutaneous injection), or a Tafamidis Product.

*Note: Examples of tafamidis products are Vyndaqel and Vyndamax.*

### II. Renewal Criteria

1. Patient continues to meet Initial approval criteria.
2. Disease response compared to baseline prior to treatment shows improvement or stabilization in one or both of the following:
  - a. Neuropathy signs and symptoms
  - b. MRC muscle strength

### Dosage/Administration

Indication	Dose
hATTR Amloidosis	<b>Recommended dosage:</b> <ul style="list-style-type: none"> <li>• Weight &lt; 100 kg</li> </ul>

	<ul style="list-style-type: none"> <li>○ 0.3 mg/kg intravenously every 3 weeks</li> <li>• Weight ≥ 100 kg <ul style="list-style-type: none"> <li>○ 30 mg intravenously every 3 weeks</li> </ul> </li> </ul> <p><b>Preparing for Therapy:</b></p> <ul style="list-style-type: none"> <li>• Dosing is based on actual body weight</li> <li>• Patients should be premedicated with a corticosteroid, acetaminophen and antihistamines.</li> <li>• Infusion should be filtered and diluted and infused, via a pump, over at least 80 minutes.</li> <li>• Patients should receive vitamin A supplementation.</li> </ul>
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## Applicable Procedure Codes

Code	Description
J0222	Injection, patisiran, 0.1mg

## Applicable NDCs

Code	Description
71336-1000-01	Onpattro 10mg/5ml single-dose vial

## ICD-10 Diagnoses

Code	Description
E85.1	Neuropathic heredofamilial amyloidosis

## Revision History

Company(ies)	DATE	REVISION
EmblemHealth & ConnectiCare	1/31/2024	Annual Review: added FAP to title for clarity, (was already in criteria); added "Concomitant Use With Amvuttra (vutrisiran subcutaneous injection), Tegsedi (inotersen subcutaneous injection), Wainua (eplontersen subcutaneous injection), or a Tafamidis Product." to limitations/Exclusions
EmblemHealth & ConnectiCare	6/02/2023	Updated length of authorization for renewal criteria: Renewal criteria is 12 months
EmblemHealth & ConnectiCare	5/30/2023	Annual Review: no criteria changes
EmblemHealth & ConnectiCare	09/15/2022	Transferred policy to new template
EmblemHealth & ConnectiCare	7/7/2021	Removed C Code
EmblemHealth & ConnectiCare	12/30/2020	Annual review: no policy changes

EmblemHealth & ConnectiCare	8/15/2019	Added code J0222, effective 10/1/19.
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## References

1. ONPATTRO (patisiran) [package insert]. Cambridge, MA: Alnylam Pharmaceuticals, Inc; Revised February, 2020.
2. Adams D, González-Duarte A, O’Riordan WD, et al. Patisiran, an RNAi therapeutic, for hereditary transthyretin amyloidosis. *N Engl J Med*. 2018;379(1):11-21.
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