

<b>Effective date:</b> 11/2019
<b>Review date:</b> 8/19, 7/20, 5/21, 5/22, 01/23
<b>Scope:</b> Medicaid

# SPECIALTY GUIDELINE MANAGEMENT

## TEGSEDI (inotersen)

### POLICY

#### I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met, and the member has no exclusions to the prescribed therapy.

##### FDA-Approved Indications

Tegsedi is indicated for the treatment of the polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults.

All other indications are considered experimental/investigational and not medically necessary.

#### II. REQUIRED DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review:

- A. Testing or analysis confirming a mutation of the TTR gene
- B. Medical record documentation confirming the member demonstrates signs and symptoms of polyneuropathy and an improvement in these signs and symptoms since starting therapy for continuation

#### III. PRESCRIBER SPECIALTIES

This medication must be prescribed by or in consultation with a neurologist, geneticist, or physician specializing in the treatment of amyloidosis.

#### IV. CRITERIA FOR INITIAL APPROVAL

##### **Polyneuropathy of Hereditary Transthyretin-mediated Amyloidosis**

Authorization of 6 months may be granted for treatment of polyneuropathy of hereditary transthyretin-mediated amyloidosis (also called transthyretin-type familial amyloid polyneuropathy [ATTR-FAP]) when all of the following criteria are met:

- A. The diagnosis is confirmed by detection of a mutation of the TTR gene.
- B. Member exhibits clinical manifestations of ATTR-FAP (e.g., amyloid deposition in biopsy specimens, TTR protein variants in serum, progressive peripheral sensory-motor polyneuropathy).
- C. The member is not a liver transplant recipient.
- D. The requested medication will not be used in combination with patisiran (Onpattro) or tafamidis (Vyndagel/Vyndamax or vutrisiran (Amvuttra).

#### V. CONTINUATION OF THERAPY

Authorization of 6 months may be granted for the continued treatment of ATTR-FAP when all of the following criteria are met:

- A. The member must have met all initial authorization criteria.
- B. The member must have demonstrated a beneficial response to treatment with Tegsedi 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

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score, polyneuropathy disability (PND) score, FAP disease stage, manual grip strength). Documentation from the medical record must be provided.

## VI. REFERENCES

1. Tegsedi [package insert]. Boston, MA: Akcea Therapeutics, Inc. June 2022.
2. Benson MD, et. al., Inotersen Treatment for Patients with Hereditary Transthyretin Amyloidosis. N Engl J Med. 2018 Jul 5; 379(1):22-31.
3. Ando Y, Coelho T, Berk JL, Cruz MW, Ericzon BG, Ikeda S, Lewis WD, Obici L, Planté-Bordeneuve V, Rapezzi C, et al. Guideline of transthyretin-related hereditary amyloidosis for clinicians. Orphanet J Rare Dis. 2013;8:31.