Drug and Biologic Coverage Policy

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Coverage Policy Number IP0137

Casimersen

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Related Coverage Resources

Genetic Testing for Hereditary and Multifactorial Conditions – (0052)

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This policy supports medical necessity review for casimersen (**Amondys 45™**).

Receipt of sample product does not satisfy any criteria requirements for coverage.

Medical Necessity Criteria

Casimersen (Amondys 45) is considered medically necessary when the following are met:

Duchenne Muscular Dystrophy (DMD). Individual meets **ALL** of the following criteria:
A. Less than age 14 years at start of therapy
B. Documented diagnosis of Duchenne muscular dystrophy is confirmed by a pathogenic or likely pathogenic variant in the *DMD* gene that is amenable to exon 45 skipping
C. Able to walk a distance of at least 300 meters independently over 6 minutes
D. Forced vital capacity is at least 50%

E. Medication is prescribed by, or in consultation with, a neurologist, neuromuscular specialist or by a Muscular Dystrophy Association clinic

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Reauthorization Criteria

Continuation of casimersen (Amondys 45) is considered medically necessary for Duchenne muscular dystrophy when the above medical necessity criteria are met AND there is documentation of beneficial response, including the continued ability to walk.

Authorization Duration

Initial approval duration: up to 6 months
Reauthorization approval duration: up to 6 months

Conditions Not Covered

Any other use is considered experimental, investigational, or unproven, including the following (this list may not be all inclusive):

Concurrent use with other exon-skipping DMD agents: Currently, there is no clinical evidence to support concurrent use of exon-skipping agents for the treatment of DMD.

Coding Information

1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

HCPCS Codes	Description
J1426	Injection, casimersen, 10 mg

Background

OVERVIEW
Amondys 45, an antisense oligonucleotide, is indicated for the treatment of **Duchenne muscular dystrophy** (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 45 skipping.[1] This indication was granted accelerated approval based on an increase in dystrophin in skeletal muscle observed in patients treated with Amondys 45. The prescribing information notes that continued FDA-approval for this indication may be contingent upon verification of clinical benefit in a confirmatory trial.

Guidelines
Amondys 45 is not addressed in the guidelines for the diagnosis and management of DMD available from the DMD Care Considerations Working Group (2018).[2] Glucocorticoids slow decline in muscle strength and function in DMD and should be considered for all patients with DMD. Exondys 51 (eteplirsen intravenous infusion) is mentioned as an emerging product, approved by an accelerated pathway for those with a mutation in the dystrophin gene amenable to exon 51 skipping.

Efficacy
Amondys 45 is under evaluation in one ongoing, Phase III pivotal study (ESSENCE) in patients with DMD amenable to exon 45 skipping.[1] The primary endpoint is the effect of Amondys 45 change from baseline in the total distance walked during the 6-Minute Walk Test (6MWT) at Week 96.[5] Functional outcomes were among the secondary endpoints. In an interim analysis from 43 evaluable patients (n = 27 treated with Amondys 45; n = 16 treated with placebo), the proportion of normal dystrophin protein level was higher at Week 48 with Amondys 45 (1.74% of normal at Week 48 vs. 0.93% of normal at baseline) vs. placebo (0.76% of normal at Week 48 vs. 0.54% of normal at baseline) [P = 0.004 for Amondys 45 vs. placebo).[1] Results from the primary endpoint (6MWT) and functional outcomes have not been reported.

Genetic Mutations
Illustrated below are deletions that would be amenable to exon-45 skipping, this list may not be all inclusive.[5]

7-44				
12-44	18-44			
44	46	46-47	46-48	46-49
46-51	46-53	46-55	46-57	46-59
46-60	46-67	46-69	46-75	46-78

FDA Recommended Dosing
The recommended dosage of Amondys 45 is 30 milligrams per kilogram administered once weekly as a 35 to 60-minute intravenous infusion via an in-line 0.2 micron filter.[1]

If a dose of Amondys 45 is missed, it may be administered as soon as possible after the scheduled dose.

References

1. Amondys 45 intravenous infusion [prescribing information]. Cambridge, MA: Sarepta; February 2021.
2. Birnkrant DJ, Bushby K, Bann CM, et al. Diagnosis and management of Duchenne muscular dystrophy, part 1: diagnosis, and neuromuscular, rehabilitation, endocrine, and gastrointestinal and nutritional management. *Lancet Neurol*. 2018;17(3):251-267.
3. Shimizu-Motohashi Y, Murakami T, Kimura E, et al. Exon skipping for Duchenne muscular dystrophy: a systematic review and meta-analysis. *Orphanet J Rare Dis*. 2018;13(1):93.
4. US National Institutes of Health. In: ClinicalTrials.gov [Internet]. Bethesda (MD): National Library of Medicine (US). 2000- [cited 2023 Feb 10]. Available from: https://clinicaltrials.gov/ct2/show/NCT02500381. Search term: NCT02500381.
5. CureDuchenne [Web site]. Available at: https://www.cureduchenne.org/cure/exon-skipping/. Accessed on April 4, 2023.