**ONPATTRO™ (PATISIRAN)**

**Policy Number:** 2019D0072F  
**Effective Date:** October 1, 2019

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### Coverage Rationale

Onpattro (patisiran) is proven for the treatment of the polyneuropathy of hereditary transthyretin-mediated (hATTR) amyloidosis.

Onpattro (patisiran) is medically necessary for the treatment of the polyneuropathy of hATTR amyloidosis in patients who meet ALL of the following criteria:

- **For initial therapy, all** of the following:
  - **Both** of the following:
    - Diagnosis of hATTR amyloidosis with polyneuropathy
    - Documentation that the patient has a pathogenic TTR mutation (e.g., V30M) and
  - Prescribed by or in consultation with a neurologist; **and**
  - Documentation of **one** of the following:
    - Patient has a baseline polyneuropathy disability (PND) score ≤ IIIb
    - Patient has a baseline FAP Stage 1 or 2
    - Patient has not had a liver transplant; **and**
  - Presence of clinical signs and symptoms of the disease (e.g., peripheral sensorimotor polyneuropathy, autonomic neuropathy, motor disability, etc.); **and**
  - Patient is not receiving Onpattro in combination with either of the following:
    - Oligonucleotide agents [e.g., Tegsedi (inotersen)]
    - Vyndaqel (tafamidis meglumine) or Vyndamax (tafamidis)
    - Patisiran dosing is in accordance with the US Food and Drug Administration prescribing information (0.3 mg/kg up to a maximum of 30mg, every 3 weeks); **and**
  - Initial authorization is for no more than 12 months.

- **For continuation therapy, all** of the following:
  - Patient has previously received treatment with Onpattro; **and**
  - Prescribed by or in consultation with a neurologist; **and**
  - Documentation of **one** of the following:
    - Patient continues to have a polyneuropathy disability (PND) score ≤ IIIb
    - Patient continues to have a FAP Stage 1 or 2
    - Documentation that the patient has experienced a positive clinical response to Onpattro (e.g., improved neurologic impairment, motor function, quality of life, slowing of disease progression, etc.); **and**
- Patient is not receiving Onpattro in combination with either of the following:
  - Oligonucleotide agents [e.g., Tegsedi (inotersen)]
  - Vyndaqel (tafamidis meglumine) or Vyndamax (tafamidis)
  - 
- Patisiran dosing is in accordance with the US Food and Drug Administration prescribing information (0.3 mg/kg up to a maximum of 30mg, every 3 weeks); and
- Authorization is for no more than 12 months.

**Onpattro (patisiran) is unproven and not medically necessary for the treatment of:**
- Sensorimotor or autonomic neuropathy not related to hATTR amyloidosis
- Primary or leptomeningeal amyloidosis

**APPLICABLE CODES**

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply.

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<tr>
<th>HCPCS Code</th>
<th>Description</th>
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<tr>
<td>J0222</td>
<td>Injection, patisiran, 0.1 mg</td>
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<tr>
<th>ICD-10 Diagnosis Code</th>
<th>Description</th>
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<tr>
<td>E85.1</td>
<td>Neuropathic heredofamilial amyloidosis</td>
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**BACKGROUND**

Hereditary ATTR (hATTR) amyloidosis, formerly known as familial amyloid polyneuropathy, is a progressive, disabling and life-threatening polyneuropathy affecting the peripheral and autonomic nervous system. This disease is an autosomal transmission disorder which is usually due to a point mutation of the transthyretin (TTR) gene. The disease is caused by misfolded transthyretin (TTR) protein that accumulates as amyloid fibrils in multiple organs, including the nerves, heart, and gastrointestinal tract.

Onpattro (patisiran) is a double-stranded small interfering RNA (siRNA) that targets a sequence of mRNA conserved across wild-type and all TTR variants and can thereby degrade and reduce serum levels and protein deposits in tissues of both wild-type and mutant protein. It is formulated as lipid nanoparticles which direct it to the liver, the primary source of circulating TTR. Patisiran therapy is associated with observed lowering of TTR levels in both wild-type and mutant (V30M) forms of TTR.

A genetic testing service is available in the United States and Canada and a genetic counseling service is available in the United States. Medical professionals and patients may access information on the Alnylam Pharmaceuticals website.

**BENEFIT CONSIDERATIONS**

Some Certificates of Coverage allow for coverage of experimental/investigational/unproven treatments for life-threatening illnesses when certain conditions are met. The member specific benefit plan document must be consulted to make coverage decisions for this service. Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances when certain conditions are met. Where such mandates apply, they supersede language in the benefit document or in the medical or drug policy. Benefit coverage for an otherwise unproven service for the treatment of serious rare diseases may occur when certain conditions are met. Refer to the Policy and Procedure addressing the treatment of serious rare diseases.

**CLINICAL EVIDENCE**

A randomized, double-blind, placebo-controlled, phase III, global study (APOLLO) evaluated the efficacy and safety of patisiran in patients with hATTR amyloidosis with polyneuropathy. Adult patients 18 to 85 years of age were eligible for the study if the investigatory estimated survival to be ≥ 2 years, Neuropathy Impairment Score (NIS) of 5 to 130, and polyneuropathy disability score ≤ IIIb. Patients were randomized 2:1 (N =148:77) to receive either intravenous (IV) patisiran 0.3 mg/kg or placebo every 3 weeks. The primary endpoint was to determine the efficacy of patisiran at 18 months based on the difference in the change in modified NIS+7 (a composite measure of motor strength, sensation, reflexes, nerve conduction, and autonomic function) between the patisiran and placebo groups. Secondary
In a subpopulation analysis of the APOLLO trial, investigators evaluated the treatment association of patisiran with regional left ventricular (LV) myocardial strain in cardiac manifestation in hATTR.\textsuperscript{11,12} The prespecified cardiac subpopulation (126 of 225 [56%]) comprised of patients with a baseline LV wall thickness of 13 mm or more and no history of hypertension or aortic valve disease. Of the 126 patients included in the prespecified cardiac subpopulation, 36 patients (28.6%) received placebo and 90 patients (71.4%) received patisiran. At baseline, LV global longitudinal strain (GLS) was impaired and regional longitudinal strains were lowest in the basal segments with apical sparing. There were no differences in regional longitudinal strains between the treatment groups at baseline. Patisiran improved the absolute GLS (least-squares mean [SE] difference, 1.4% [0.6%]; 95% CI, 0.3%–2.5%; P = .02) compared with placebo at 18 months, with the greatest differential increase observed in the basal region (overall least-squares mean [SE] difference, 2.1% [0.8%]; 95% CI, 0.6%–3.6%; P = .006) and no significant differences in the mid and apical regions among groups. Patisiran reduced mean left ventricular wall thickness (least-squares mean difference ± SEM: −0.9±0.4 mm, P=0.017), interventricular septal wall thickness, posterior wall thickness, and relative wall thickness at month 18 compared with placebo. Patisiran also led to increased end-diastolic volume (8.3±3.9 mL, P=0.036), decreased global longitudinal strain (−1.4±0.6%, P=0.015), and increased cardiac output (0.38±0.19 L/min, P=0.044) compared with placebo at month 18. Patisiran lowered N-terminal prohormone of brain natriuretic peptide at 9 and 18 months (at 18 months, ratio of fold-change patisiran/placebo 0.45, P<0.001). A consistent effect on N-terminal prohormone of brain natriuretic peptide at 18 months was observed in the overall APOLLO patient population (n=225). Median follow-up duration was 18.7 months. The exposure-adjusted rates of cardiac hospitalizations and all-cause death were 18.7 and 10.1 per 100 patient-years in the placebo and patisiran groups, respectively (Andersen–Gill hazard ratio, 0.54; 95% CI, 0.28–1.01). The authors concluded that patisiran prevented the deterioration of LV GLS and decreased mean LV wall thickness over 18 months, suggesting that patisiran may halt or reverse the progression of the cardiac manifestations of hATTR amyloidosis.

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

Onpattro™ (patisiran) contains a transthyretin-directed small interfering RNA and is indicated for the treatment of the polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Medicare does not have a National Coverage Determination (NCD) for ONPATTRO® (patisiran). Local Coverage Determinations (LCDs) do not exist at this time.

In general, Medicare covers outpatient (Part B) drugs that are furnished "incident to" a physician’s service provided that the drugs are not usually self-administered by the patients who take them. Refer to the Medicare Benefit Policy Manual, Chapter 15, 850 - Drugs and Biologics. (Accessed April 11, 2019)

REFERENCES


POLICY HISTORY/REVISION INFORMATION

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| 10/01/2019 | • Updated list of applicable HCPCS codes to reflect quarterly code edits:  
|            | o Replaced J3490 with J0222  
|            | o Removed C9036  

Supporting Information

• Archived previous policy version 2018D0072E

INSTRUCTIONS FOR USE

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard benefit plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Benefit Drug Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare Medical Benefit Drug Policies 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.