Spinraza™ (Nusinersen) is proven and medically necessary for the treatment of Spinal Muscular Atrophy (SMA) in patients who meet all of the following criteria:

I. For initial therapy, all of the following:
   A. Diagnosis of spinal muscular atrophy type I, II, or III by, or in consultation with, a neurologist with expertise in the diagnosis of SMA; and
   B. Submission of medical records (e.g., chart notes, laboratory values) confirming both of the following:
      1. The mutation or deletion of genes in chromosome 5q resulting in one of the following:
         a. Homozygous gene deletion or mutation (e.g., homozygous deletion of exon 7 at locus 5q13)\(^1,5\); or
         b. Compound heterozygous mutation (e.g., deletion of SMN1 exon 7[allele 1] and mutation of SMN1 [allele 2])
            and
      2. Patient has at least 2 copies of SMN2
   and
   C. Patient is not dependent on either of the following:
      1. Invasive ventilation or tracheostomy
      2. Use of non-invasive ventilation beyond use for naps and nighttime sleep
         and
   D. Submission of medical records (e.g., chart notes, laboratory values) of the baseline exam of at least one of the following exams (based on patient age and motor ability) to establish baseline motor ability:
      1. Hammersmith Infant Neurological Exam Part 2 (HINE-2)\(^1,8,12\) (infant to early childhood)
      2. Hammersmith Functional Motor Scale Expanded (HFMSE)\(^1,9,13-14\)
      3. Upper Limb Module (ULM) Test (Non ambulatory)\(^1,9\)
      4. Children’s Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)\(^1,8\)
         and
   E. Spinraza is prescribed by, or in consultation with, a neurologist with expertise in the treatment of SMA; and
   F. One of the following:
      1. Patient has not previously received gene replacement therapy for the treatment of SMA; or
      2. One of the following:
         a. Both of the following:
            i. Patient recently received gene replacement therapy within the previous 6 months; and
            ii. Patient has experienced a decline in clinical status since receipt of gene replacement therapy or
         b. Both of the following:
            i. Patient has previously received gene replacement therapy; and
ii. Patient has experienced a decline in clinical status that represents a potential abatement of
gene therapy efficacy

and

G. Spinraza is to be administered intrathecally by, or under the direction of, healthcare professionals experienced
in performing lumbar punctures; and

H. Spinraza dosing for SMA is within accordance with the United States Food and Drug Administration approved
labeling: maximum dosing of 12mg for each loading dose; and

I. Initial authorization will be for no more than 4 loading doses.

II. For continuation therapy, all of the following:
A. Diagnosis of spinal muscular atrophy type I, II, or III by, or in consultation with, a neurologist with expertise
in the diagnosis of SMA; and

B. Submission of medical records (e.g., chart notes, laboratory values) confirming both of the following:
   1. The mutation or deletion of genes in chromosome 5q resulting in one of the following:
      a. Homozygous gene deletion or mutation (e.g., homozygous deletion of exon 7 at locus 5q13)\(^1\); or
      b. Compound heterozygous mutation (e.g., deletion of SMN1 exon 7[allele 1] and mutation of SMN1
         [allele 2])
   and
   2. Patient has at least 2 copies of SMN2
   and

C. Patient is not dependent on either of the following:
   1. Invasive ventilation or tracheostomy
   2. Use of non-invasive ventilation beyond use for naps and nighttime sleep
   and

D. One of the following:
   1. Patient has not previously received gene replacement therapy for the treatment of SMA; or
   2. Both of the following:
      a. Patient has previously received gene replacement therapy; and
      b. Patient has experienced a decline in clinical status that represented a potential failure or
         abatement of gene therapy efficacy
   and

E. Submission of medical records (e.g., chart notes, laboratory values) with the most recent results (< 1 month
prior to request) documenting a positive clinical response from pretreatment baseline status to Spinraza
therapy as demonstrated by at least one of the following exams:
   1. HINE-2 milestones:
      a. One of the following:
         i. Improvement or maintenance of previous improvement of at least 2 point (or maximal score)
            increase in ability to kick
         ii. Improvement or maintenance of previous improvement of at least 1 point increase in any other
            HINE-2 milestone (e.g., head control, rolling, sitting, crawling, etc.), excluding voluntary grasp
            and
         b. One of the following:
            i. The patient exhibited improvement, or maintenance of previous improvement in more HINE motor
               milestones than worsening, from pretreatment baseline (net positive improvement)
            ii. Achieved and maintained any new motor milestones when they would otherwise be unexpected to
do so (e.g., sit unassisted, stand, walk)
      or
   2. HFMSE: One of the following:
      a. Improvement or maintenance of previous improvement of at least a 3 point increase in score from
         pretreatment baseline
      b. Patient has achieved and maintained any new motor milestone from pretreatment baseline when they
         would otherwise be unexpected to do so
      or
   3. ULM: One of the following:
      a. Improvement or maintenance of previous improvement of at least a 2 point increase in score from
         pretreatment baseline
      b. Patient has achieved and maintained any new motor milestone from pretreatment baseline when they
         would otherwise be unexpected to do so
      or
   4. CHOP INTEND: One of the following:
      a. Improvement or maintenance of previous improvement of at least a 4 point increase in score from
         pretreatment baseline
b. Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

or

5. Both of the following:
   a. Patient was prescribed Spinraza due to clinical declination after receipt of gene therapy; and
   b. Patients clinical status has stabilized after receipt of Spinraza therapy

and

F. Spinraza is prescribed by, or in consultation with, a neurologist with expertise in the treatment of SMA; and
G. Spinraza is to be administered intrathecally by, or under the direction of, healthcare professionals experienced in performing lumbar punctures; and
H. Spinraza dosing for SMA is within accordance with the United States Food and Drug Administration approved labeling: maximum dosing of 12mg every 4 months, starting 4 months after the last loading dose; and
I. Reauthorization will be for no more than 3 maintenance doses (12 months).

Spinraza is not proven or medically necessary for spinal muscular atrophy without chromosome 5q mutations or deletions. Spinraza is not proven or medically necessary for routine concomitant treatment of SMA in patients who have previously received gene replacement therapy.

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

Spinraza is a survival motor neuron-2 (SMN2)-directed antisense oligonucleotide indicated for the treatment of spinal muscular atrophy (SMA) in pediatric and adult patients.

BACKGROUND

Spinal muscular atrophy (SMA) is a rare, autosomal recessive neuromuscular disease that affects the survival of motor neurons of the spinal cord. SMA is caused by the deletion/mutation of the SMN1 gene. The estimated annual incidence of SMA is 5.1 to 16.6 cases per 100,000 live births. Approximately 1/40 to 1/60 people are SMA carriers, equating to 3.5 to 5.2 million and 12 to 18 million individuals in the United States and Europe, respectively. SMA is characterized by the degeneration of motor neurons of the spinal cord, resulting in hypotonia and muscle weakness. Five phenotypic subtypes of SMA (0-IV) have been described based on age of symptom onset and motor function achieved. Current literature indicates that the number of copies of the SMN2 gene that a patient has is the best predictor of clinical phenotype. The table below summarizes the clinical and genetic characteristics of the SMA subtypes.

<table>
<thead>
<tr>
<th>Clinical SMA Diagnosis</th>
<th>% of SMA cases</th>
<th>Usual Number of SMN2 copies</th>
<th>Typical age of symptom onset</th>
<th>Life expectancy</th>
<th>Motor development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 0</td>
<td>Very rare</td>
<td>1</td>
<td>In utero</td>
<td>Death occurs shortly after birth</td>
<td>None</td>
</tr>
<tr>
<td>Type I</td>
<td>58%</td>
<td>2</td>
<td>&lt; 6 months</td>
<td>&lt; 24 months</td>
<td>Never able to sit</td>
</tr>
<tr>
<td>Type II</td>
<td>29%</td>
<td>2-4 (80% have 3 copies)</td>
<td>&lt; 18 months</td>
<td>70% alive at 25 years</td>
<td>Unable to walk without assistance</td>
</tr>
<tr>
<td>Type III</td>
<td>13%</td>
<td>95% have ≥ 3 copies</td>
<td>May be normal</td>
<td>Normal</td>
<td>Ambulatory. May experience mild muscle weakness</td>
</tr>
<tr>
<td>Type IV</td>
<td>&lt;5%</td>
<td>≥ 4</td>
<td>20-30 years</td>
<td>Normal</td>
<td></td>
</tr>
</tbody>
</table>

The severity of the clinical phenotype is heterogenous with the most severe form, type I SMA, occurring in infancy. The median survival of a patient with type I SMA is 7 months. The later-onset forms, type II and type III, cause a less severe motor disability. The Hammersmith Functional Motor Score Expanded (HFMSE) is a common assessment tool used to evaluate later-onset SMA. The HFMSE is a 33-item measure of motor function that is specifically validated for use in patients with SMA to assess activities related to daily living. The total score can range from 0-66 with higher scores indicating better motor function. A change in HFMSE score of at least 3 points is considered clinically meaningful. The natural history of patients with type II/III SMA has been described in two recent publications. A 2012 study reported a mean HFMSE decline of -0.54 over 2 years in type 2 SMA. A 2016 publication attempted to describe the patterns of disease progression for patients with type 2/3 SMA. The results obtained in 268 patients found that patients show small mean changes over a 12-month period on the HFMSE. The vast majority of patients...
(over 75%) had changes ±2 points, with less than 10% showing an improvement of more than 2 points, in agreement with previously reported data.28

Spinraza™ (nusinersen) is a modified antisense oligonucleotide designed to treat SMA caused by mutations in chromosome 5q that lead to SMN protein deficiency. Nusinersen binds to a specific sequence in the intron downstream of exon 7 of the SMN2 transcript. Using in vitro assays and studies in transgenic animal models of SMA, nusinersen was shown to increase exon 7 inclusion in SMN2 messenger ribonucleic acid (mRNA) transcripts and production of full-length SMN protein.1 The FDA approved Spinraza on December 23, 2016. According to the FDA, the Spinraza approval was supported by the single pivotal randomized sham-procedure controlled phase 3 study in infantile-onset (Type I) SMA patients. FDA review of open-label trials with Spinraza, while not enough support for FDA approval alone, allowed reasonable extrapolation of benefit of Spinraza for the later onset (Type II and III) SMA subtypes. During the FDA review, the clinical data from the pivotal randomized sham-procedure controlled phase 3 study in later-onset SMA (likely Type II or III) was not reviewed as the trial was ongoing. The manufacturer did provide topline results from interim analysis of the data that along with the open-label data, allowed reasonable extrapolation of benefit to the other SMA subtypes.2

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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<th>HCPCS Code</th>
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<td>J2326</td>
<td>Injection, nusinersen, 0.1 mg</td>
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<table>
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<tr>
<th>ICD-10 Diagnosis Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>G12.0</td>
<td>Infantile spinal muscular atrophy, type I [Werdnig-Hoffmann]</td>
</tr>
<tr>
<td>G12.1</td>
<td>Other inherited spinal muscular atrophy</td>
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</table>

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. See the Policy and Procedure addressing the treatment of serious rare diseases.

CLINICAL EVIDENCE

Pre-Symptomatic Patients Likely to Develop Type I SMA

An ongoing phase 2 clinical trial (NURTURE) is evaluating the effect of Spinraza treatment on pre-symptomatic SMA patients.22 Twenty-five patients with an SMN1 deletion with two or three copies of SMN2 received Spinraza treatment before 6 weeks of age, in advance of the onset of overt disease symptoms. The NURTURE trial is an open-label, single-arm study comparing pre-symptomatic Spinraza efficacy to a control group of affected siblings and natural history data. Initial results from the second interim analysis indicate that motor milestones (such as sitting and crawling) are generally achieved at age-appropriate time points.23

Type I SMA

An open-label, phase 2, escalating dose clinical study (CS3A) assessed the safety and tolerability, pharmacokinetics, and clinical efficacy of multiple intrathecal doses of nusinersen (6 mg and 12 mg dose equivalents) in patients with infantile-onset spinal muscular atrophy. Eligible participants were of either gender aged between 3 weeks and 7 months old with onset of spinal muscular atrophy symptoms between 3 weeks and 6 months, who had SMN1 homozygous gene deletion or mutation. Twenty participants were enrolled between May 3, 2013, and July 9, 2014. In the 12 mg dose group, incremental achievements of motor milestones (p<0.0001), improvements in CHOP-INTEND motor function scores (p=0.0013), and increased compound muscle action potential amplitude of the ulnar nerve (p=0.0103) and peroneal nerve (p<0.0001), compared with baseline, were observed. Median age at death or permanent ventilation was not reached and the Kaplan-Meier survival curve diverged from a published natural history...
case series (p=0.0014). Analysis of autopsy tissue from patients exposed to nusinersen showed drug uptake into motor neurons throughout the spinal cord and neurons and other cell types in the brainstem and other brain regions, exposure at therapeutic concentrations, and increased SMN2 mRNA exon 7 inclusion and SMN protein concentrations in the spinal cord. An exposure response analysis of this clinical study suggested that the dose level of 12 mg was more efficacious than 6 mg. This analysis led to an amendment in the phase 3 ENDEAR study in patients with type I SMA to increase the studied dosage regimen to what is currently FDA labeled.

A Phase 3, multicenter, randomized, double-blind, sham-procedure controlled study (ENDEAR study) assessed the clinical efficacy and safety of nusinersen, administered intrathecally in 121 symptomatic infants, ≤ 7 months of age at the time of first dose, diagnosed with SMA (symptom onset before 6 months of age). Patients were randomized 2:1 to receive either nusinersen or sham injection. Patients received nusinersen 12mg, or sham procedure on day 1, 15, 29, 64 and then maintenance dosing of 12 mg every 4 months. A planned interim efficacy analysis was conducted based on patients who died, withdrew, or completed at least 183 days of treatment. Of the 82 patients included in the interim analysis, 44% were male and 56% were female. Age at first treatment ranged from 30 to 262 days (median 181). Eighty-seven (87%) of subjects were Caucasian, 2% were Black, and 4% were Asian. Length of treatment ranged from 6 to 442 days (median 261 days). Baseline demographics were balanced between the nusinersen and control groups with the exception of age at first treatment (median age 175 vs. 206 days, respectively). The nusinersen and control groups were balanced with respect to gestational age, birth weight, disease duration, and SMN2 copy number (2 copies in 98% of subjects in both groups). Median disease duration was 14 weeks. There was some imbalance in age at symptom onset with 88% of subjects in the nusinersen group and 77% in the control group experiencing symptoms within the first 12 weeks of life. The primary endpoint assessed at the time of interim analysis was the proportion of responders: patients with an improvement in motor milestones according to Section 2 of the Hammersmith Infant Neurologic Exam (HINE). A treatment responder was defined as any patient with at least a 2-point increase (or maximal score of 4) in ability to kick (consistent with improvement by at least 2 milestones), or at least a 1-point increase in the motor milestones of head control, rolling, sitting, crawling, standing or walking (consistent with improvement by at least 1 milestone). To be classified as a responder, patients needed to exhibit improvement in more categories of motor milestones than worsening. Of the 82 patients who were eligible for the interim analysis, a statistically significantly greater percentage of patients achieved a motor milestone response in the nusinersen group compared to the sham-control group. Fifty-one percent of patients in the nusinersen group achieved the definition of a motor milestone responder compared to 0% of patients in the sham-control group. The primary endpoint assessed at the final analysis was time to death or permanent ventilation (≥ 16 hours ventilation/day continuously for > 21 days in the absence of an acute reversible event or tracheostomy). Statistically significant effects on event-free survival and overall survival were observed in patients in the nusinersen group compared to those in the sham-control group. A 47% reduction in the risk of death or permanent ventilation was observed in the nusinersen group (p=0.005). Median time to death or permanent ventilation was not reached in nusinersen group and was 22.6 weeks in the sham-control group. A statistically significant 63% reduction in the risk of death was also observed (p=0.004).\(^1\)\(^,\)\(^4\)

**Type II/III SMA**

An open-label, phase 1 single dose, dose escalation study (CS1) assessed the safety, tolerability, and pharmacokinetics of nusinersen in 28 patients with SMA aged 2 to 14 years. Four dose cohorts were evaluated. Patients received a single dose of 1 mg, 3 mg, 6 mg, or 9 mg and were evaluated at day 29 and 85 for the 6 mg and 9 mg dosing cohorts. The mean change in HFMSE from baseline in the 9 mg single dose cohort at day 29 and 85 was 2.4 and 3.1 respectively.

An open-label, phase 1 single dose study (CS10) assessed the safety, tolerability, and pharmacokinetics of a single subsequent dose nusinersen in patients with SMA who previously participated in the CS1 study. Patients were to receive either 6 mg or 9 mg of nusinersen, however the study was amended after 4 subjects were enrolled to a single 9 mg dose. Patients were to receive a subsequent nusinersen dose 9 to 15 months after the initial dose in the CS1 study. Eighteen patients were enrolled, eight of which were in the 9 mg cohort 4 in CS1. The mean change in HFMSE from CS1 baseline in the 8 CS1 cohort 4 patients was 5.8 9-14 months after initial dosing in CS1. The mean change in HFMSE from CS1 baseline at approximately 15 to 18 months after two 9 mg doses of nusinersen was 6.1.

An open-label, dose escalation study (CS2 study) assessed the safety, tolerability and dose range of nusinersen in SMA patients aged 2 to 15 years. Four dose cohorts (3, 6, 9, and 12) were evaluated. Cohort 1 (3 mg), 2 (6 mg), and 4 (12 mg) received nusinersen on days 1, 29, and 85. Cohort 3 (9 mg) received nusinersen on days 1 and 85. Exploratory efficacy variables included HFMSE, Pediatric Quality of Life Inventory, compound muscle action potential (CMAP) and motor unite number estimation (MUNE), the Upper Limb Module test (ULMT), muscle strength using hand-held dynamometry, the 6-minute Walk Test (6MWT), and the Assessment of Caregiver Experience with Neuromuscular Disease (ACEND) questionnaire. Cohorts 1, 2, and 4 each had 8 patients and cohort 3 had 9 patients. Subjects were evaluated using the HFMSE at Baseline and on Days 92, 169, and 253. An efficacy evaluable population was also identified, this population included patients whose baseline HFMSE score was between 10 and 54. The largest mean HFMSE change from baseline was seen in cohort 3, with a mean change of 2.7, 2.9, and 3.7 at days 92, 169,
and 253 respectively. The mean HFMSE change in cohort 4 was 0.6, 1.0, and 2.3 at days 92, 169, and 253 respectively. In the efficacy evaluable population, the mean change in cohort 3 (n=8) was 2.7, 3.1, and 3.9 at days 92, 169, and 253 respectively. In the efficacy evaluable population the mean change in cohort 4 (n=5) was 1.8, 2.0, and 3.8 at days 92, 169, and 253 respectively. According to the FDA, there appeared to be a consistent trend of increasing HFME over time with nusinersen treatment in the 6mg, 9mg, and 12mg cohorts.

An open-label phase 1 study (CS12) assessed the safety, tolerability and efficacy of maintenance nusinersen in 47 patients who previously participated in either the CS2 or CS10 trial. Patients received 12 mg nusinersen at 6 month intervals and were expected to participate in CS12 for up to approximately 2 years. Efficacy parameters included the change in HFME, 6MWT, and ULMT. At day 624 the mean change in HFME was 0.47, at day 715, the median change in HFME was 0. Median scores were reported at day 715 due to a single outlier. At day 715 the mean change in ULMT was 1.0. At day 624, among the 22 patients with type III SMA who were ambulatory at baseline, the mean change in 6MWT was 26.13 meters.

A Phase 3 multicenter, double-blind, randomized, sham-procedure controlled study (CHERISH) assessed the clinical efficacy and safety of nusinersen in patients with later-onset SMA consistent with Type II or Type III SMA. Subjects were randomized 2:1 to receive intrathecal nusinersen or a sham procedure control, respectively. Patients received nusinersen 12 mg loading dose, or sham procedure on day 1, 29, 85 and then maintenance dosing of 12 mg six months after the last dose on day 274. The loading dose level and interval was selected based on the nonclinical pharmacokinetic and pharmacology data as the dose interval to achieve and maintain nusinersen spinal cord tissue levels that are predicted to be within the upper end of the pharmacologically active range following the first dose (predicted to be approximately 24 mcg/g lumbar and 8 mcg/g cervical tissue concentration at day 85), while at the same time considering subject safety and convenience for repeated LP intrathecal injections. The maintenance dose interval (once every 6 months) was selected based on the estimated spinal tissue and CSF drug half-life (4-6 months) and was selected to maintain spinal cord tissue levels of nusinersen at a steady-state level within the estimated pharmacologically active range. The CHERISH protocol was drafted, and thus the study regimen was selected, after the ENDEAR study amendment that increased the dosing frequency in patient with type 1 SMA. Inclusion criteria included diagnosis with SMA with clinical signs and symptoms consistent with SMA at greater than 6 months of age, an age of 2 to 12 years, the ability to sit independently, but never able to walk independently (defined as the ability to walk ≥ 15 ft. unaided) and have a HFME score greater than or equal to 10 and less than or equal to 54 at Screening. The primary endpoint was change from baseline in HFME score (at 15 months). Secondary Endpoints were (at 15 months): proportion of subjects who achieve a 3-point increase from baseline in HFME score, proportion of subject that achieve any new motor milestone, number of motor milestones achieved per subject, change from baseline in Upper Limb Module Test, proportion of subjects that achieve standing alone, proportion of subject that achieve walking with assistance. 126 children were enrolled in the trial with 84 receiving nusinersen. 90% of children had an SMN2 copy number of 3 or greater. In the pre-planned interim analysis, a significant difference (p = 0.0000002) of 5.9 points in HFME was observed at 15 months between patients given nusinersen (n = 84) compared to the sham-procedure control (n = 42) and the study was stopped early. Patients receiving nusinersen experienced a mean improvement of 4.0 points in the HFME compared to a mean decrease of 1.9 points in the sham procedure control group in the interim analysis. In the final analysis, Patients receiving nusinersen experienced a mean improvement of 3.9 points in the HFME compared to a mean decrease of 1.0 points in the sham procedure control group. A change of ≥ 3 points in the HFME has previously been determined to be clinically important. Subgroup analysis showed similar efficacy of nusinersen in type II/III SMA patients regardless of SMN2 copy number. 57% of the children in the nusinersen group as compared with 26% in the control group had an increase from baseline to month 15 in the HFME score of at least 3 points (p<0.001) The percentage of children who achieved at least one new motor milestone did not differ significantly between the nusinersen group and the control group. The proportion of children who had achieved the ability to stand alone or walk with assistance did not differ significantly between groups. Adverse events were mostly considered to be related to SMA disease, common events found in the general population, or events related to the lumbar puncture procedure. No patients discontinued the study. Nusinersen was well tolerated with a favorable safety profile.

At the time of FDA approval, review of the nusinersen clinical development program, including the open label phase 2 trial (CS12), the blinded phase 3 (CS4 [CHERISH]) trial, or the open-label phase 2 extension trial (CS11 [SHINE]) identified that all patients who had later-onset SMA received maintenance treatment with nusinersen at 6 month intervals, less than that listed in the FDA label. FDA review of patients in the CS12 trial, along with review of the recently published phase 3 data showed documented improvement in outcome measures, such as HFME, over the 3 years of available data with these later-onset SMA patients. Analysis of the early phase 1/2 studies (CS1, CS2, CS10, CS12), where a variety of different dosage regimens were studied in patients with later-onset SMA, appears to show the responses to nusinersen are seen early after nusinersen administration and remained stable across a variety of dosage regimens. To date, no randomized clinical trial in patients with later-onset SMA has evaluated nusinersen at a dose intensity or frequency greater than what has been described in the CHERISH trial.
Professional Societies
In 2018, the American Academy of Neurology published systematic review of the evidence for the use of nusinersen in spinal muscular atrophy. In addition, the American Academy of Pediatrics endorsed this publication. The systematic review resulted in the following: Four published clinical trials were identified, 3 of which were rated above Class IV. There is Class III evidence that in infants with homozygous deletions or mutations of SMN1, nusinersen improves the probability of permanent ventilation-free survival at 24 months vs a well-defined historical cohort. There is Class I evidence that in term infants with SMA and 2 copies of SMN2, treatment with nusinersen started in individuals younger than 7 months results in a better motor milestone response and higher rates of event-free survival than sham control. There is Class I evidence that in children aged 2–12 years with SMA symptom onset after 6 months of age, nusinersen results in greater improvement in motor function at 15 months than sham control. Nusinersen was safe and well-tolerated. The authors concluded that the evidence of efficacy is currently highest for treatment of infantile- and childhood-onset SMA in the early and middle symptomatic phases. While approved indications for nusinersen use in North America and Europe are broad, payer coverage for populations outside those in clinical trials remain variable. Evidence, availability, cost, and patient preferences all influence decisionmaking regarding nusinersen use.

In the 2018 Cure SMA Working Group treatment algorithm, the working group stresses the need for early intervention through newborn screening to maximize the benefit of treatment. The group recommends the development of dependable and validated screening techniques to enable treatment of presymptomatic patients who may be more responsive to treatment than those already experiencing symptoms. For patients with SMA Types II or III with three or fewer copies of the SMN2 gene, the group recommends immediate treatment with a disease modifying therapy and referral to both a neuromuscular specialist and a geneticist; for those with only one copy of SMN2 who are symptomatic at birth, the group states that the attending physician should determine whether the patient and family would benefit from treatment. Lastly, patients with four copies of SMN2 should be screened periodically for symptoms and referred to a geneticist to determine the exact number of SMN2 copies, but the working group recommends against immediate treatment with a disease modifying therapy.

Centers for Medicare and Medicaid Services
Medicare does not have a National Coverage Determination (NCD) for Spinraza® (nusinersen). Local Coverage Determinations (LCDs) exist; see the LCDs for Nusinersen (Spinraza).

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, §50 - Drugs and Biologicals. (Accessed January 11, 2019)

References


17. Spinraza [AMCP dossier]; Cambridge, MA: Biogen; December 2016


POLICY HISTORY/REVISION INFORMATION

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<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
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<td>03/01/2019</td>
<td>Reorganized policy template; simplified and relocated Instructions for Use and Benefit Considerations section. Policy 2018D0059D archived.</td>
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| 01/01/2018 | • Added list of applicable HCPCS codes to reflect annual code edits: J2326  
• Archived previous policy version 2017D0059B                                                                                      |
| 05/01/2017 | Updated policy. Changed non-invasive ventilation criteria to clarify intent. Approved by National Pharmacy & Therapeutics Committee on 04/26/2017. Policy 2017D0059A archived. |
| 04/01/2017 | New policy 2017D0059A. Approved by National Pharmacy & Therapeutics Committee on 01/25/2017.                                                   |

**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.