

Luxturna® (Voretigene Neparvovec-Rzyl)

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[Instructions for Use](#)

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Commercial Policy
<ul style="list-style-type: none"> Luxturna® (Voretigene Neparvovec-Rzyl)

Application

This Medical Benefit Drug Policy does not apply to the states listed below; refer to the state-specific policy/guideline, if noted:

State	Policy/Guideline
Indiana	Refer to the state’s Medicaid clinical policy
Florida	Refer to the state’s Medicaid clinical policy
Kansas	Refer to the state’s Medicaid clinical policy
Kentucky	Luxturna® (Voretigene Neparvovec-Rzyl) (for Kentucky Only)
Louisiana	Luxturna® (Voretigene Neparvovec-Rzyl) (for Louisiana Only)
North Carolina	None

Coverage Rationale

Luxturna (voretigene neparvovec) is proven and medically necessary for the treatment of inherited retinal dystrophies (IRD) caused by mutations in the retinal pigment epithelium-specific protein 65kDa (RPE65) gene in patients who meet all of the following criteria:¹⁻²

- Patient is greater than 12 months of age; and
- Diagnosis of a confirmed biallelic RPE65 mutation-associated retinal dystrophy [e.g., Leber’s congenital amaurosis (LCA), Retinitis pigmentosa (RP), Early Onset Severe Retinal Dystrophy (EOSRD), etc.]; and
- Genetic testing documenting biallelic mutations of the RPE65 gene; and
- Sufficient viable retinal cells as determined by optical coherence tomography (OCT) confirming an area of retina within the posterior pole of >100 µm thickness; and
- Prescribed and administered by ophthalmologist or retinal surgeon with experience providing sub-retinal injections; and
- Patient has not previously received RPE65 gene therapy in intended eye

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 federal, state, or contractual requirements 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 Guidelines may apply.

HCPCS Code	Description
J3398	Injection, voretigene neparovvec-rzyl, 1 billion vector genomes

Diagnosis Code	Description
H35.50	Unspecified hereditary retinal dystrophy
H35.52	Pigmentary retinal dystrophy
H35.54	Dystrophies primarily involving the retinal pigment epithelium

Background

Leber's congenital amaurosis (LCA) and autosomal recessive retinitis pigmentosa (RP) are a group of inherited, early-onset, severe retinal dystrophies that cause substantial sight impairment in childhood. One of the causes of these conditions is mutations in the gene encoding RPE65 (retinal pigment epithelium-specific protein 65 kDa). Biallelic mutations in the RPE65 gene account for approximately 16% of cases of LCA and 2% of cases of recessive RP. The encoded retinoid isomerase converts all-trans retinyl esters to 11-cis retinal for the regeneration of visual pigment after exposure to light. RPE65 deficiency causes photoreceptor-cell dysfunction and impaired vision from birth. Severe dysfunction of rod photoreceptor cells, which are wholly reliant on retinal pigment epithelium-derived RPE65, causes severely impaired night vision. The function of cone photoreceptor cells, which mediate vision in daylight, is relatively preserved in childhood because cones have access to an alternative source of 11-cis retinal. However, progressive degeneration of both rod and cone photoreceptor cells, in association with local accumulation of toxic retinyl esters, results in severe sight impairment by early adulthood.^{4,6}

Augmentation of RPE65 in animal models of RPE65 deficiency can improve retinal and visual function, as assessed by means of electroretinography (ERG) and observation of vision-guided behavior, respectively.^{3,5} Since the target retinal cells are post mitotic cells, it is expected that a one-time administration of the gene product will provide benefit as long as the retina cells are viable. Gene therapy treatment does not produce new tissue so it is vital the patient have sufficient viable retinal cells prior to administration. This can be measured by optical coherence testing (OCT) documenting a retinal layer $\geq 100\mu\text{m}$ thick.⁸

Clinical Evidence

Phase 1 trials, done at the Children's Hospital of Philadelphia, showed safe and stable improvement in retinal and visual function in all 12 participants. These individuals received unilateral, subretinal injections of AAV2-hRPE65v2 (voretigene neparovvec) in their worse-seeing, non-preferred eye in a dose-escalation study, with doses from 1.5×10^{10} to 1.5×10^{11} vector genomes (vg). Most of these participants showed improved light sensitivity, navigational abilities, or visual acuity. A follow-on study, in which 11 of these 12 participants underwent injection of the contralateral eye at the dose of 1.5×10^{11} vg, demonstrated the safety of contralateral eye injection, as well as gains in visual and retinal function in the second eye. This improvement has remained durable over at least 3 years, with observation ongoing.

An open-label randomized controlled Phase 3 study in which subjects with confirmed biallelic RPE65 mutations were randomized in a 2:1 fashion to either the voretigene neparovvec group or control group and followed for one year. After completion of one year of observation, Control subjects were allowed to crossover and receive voretigene neparovvec treatment. Enrollment criteria include the following: subjects had to be at least three years of age with confirmed biallelic RPE65 mutations, subjects had to have a visual acuity of worse than or equal to 20/60 (for both eyes) and/or visual field of less than 20 degrees in any meridian as measured by a GVF III4e isopter or equivalent (both eyes), subjects had to have sufficient viable retinal cells as determined by non-invasive means, such as OCT (defined as an area of retina within the posterior pole of > 100

microns thickness) or ophthalmoscopy, subjects had to have the ability to comprehend the MLMT, follow course instructions, and the capacity to successfully navigate the course, and subjects had to have a baseline score on the MLMT that would allow a measurable improvement to be observed. The pre-specified primary efficacy endpoint was the change from Baseline at Year 1 in multi-luminance mobility test (MLMT) performance using the bilateral testing condition of the intervention group compared to controls. A total of 29 subjects were randomized and received intervention, 20 to the intervention arm and 9 to control. Overall, 72% of all treated subjects (21 of 29) achieved the maximum possible MLMT improvement one-year post-administration, demonstrating significant improvement in functional vision at lower light levels. The benefits observed at one year in the original intervention group continued through at least two years post-administration, with observation ongoing.^{3,9,10}

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Luxturna is an adeno-associated virus vector-based gene therapy indicated for the treatment of patients with confirmed biallelic RPE65 mutation-associated retinal dystrophy. Patients must have viable retinal cells as determined by the treating physician(s). Treatment with Luxturna is not recommended for patients younger than 12 months of age, because the retinal cells are still undergoing cell proliferation, and Luxturna would potentially be diluted or lost during cell proliferation.³

Centers for Medicare and Medicaid Services (CMS)

Medicare does not have a National Coverage Determination (NCD) for Luxturna® (voretigene neparvovec-rzyl). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist; see the LCDs/LCAs for [Voretigene Neparvovec-rzyl \(Luxturna®\)](#).

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 October 8, 2020)

References

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Policy History/Revision Information

Date	Summary of Changes
08/01/2021	Application <ul style="list-style-type: none">Added language to indicate this policy does not apply to the states of Indiana and North Carolina
02/01/2021	Application <ul style="list-style-type: none">Reformatted contentAdded language to indicate this policy does not apply to the state of Kentucky; refer to the state-specific policy version
12/01/2020	Application <ul style="list-style-type: none">Added language to indicate this policy does not apply to the state of Louisiana; refer to the state-specific policy versionReplaced language indicating “this policy does not apply to the state of Florida (<i>MMA product only</i>)” with “this policy does not apply to the state of Florida”Added instruction for the states of Florida and Kansas to refer to the state's Medicaid clinical policy Supporting Information <ul style="list-style-type: none">Updated <i>CMS</i> section to reflect the most current informationArchived previous policy version CS2019D0064E

Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. 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.

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