Network Notifications

New Hampshire

WellSense HEALTH PLAN

Date:	July 31, 2024	Number: 102
To:	All WellSense Providers	
From:	WellSense Health Plan	
Subject:	**July Medical Policy Network Notification**	
Product:	☒ NH Medicaid ☒ NH Medicare Advantage	

July Medical Policy Network Notification

Effective October 1, 2024, we'll be introducing several new medical policies across all plan types:

- Imlygic® (talimogene laherparepvec), OCA 3.219
- Laviv® (azficel-T), OCA 3.220
- Zolgensma® (onasemnogene abeparvovec), OCA 3.213

We've attached copies of these policies to this notification.

Effective October 1, 2024, we'll be adopting InterQual® criteria for Hemgenix® (etranacogene dezaparvovec-drlb).

General Information

All WellSense medical policies are on the provider policies page at wellsense.org.

Questions?

If you have questions about this network notification, please contact your dedicated Provider Relations Consultant or call 877-957-1300, option 3 (NH Medicaid) or 866-808-3833 (Medicare Advantage). You can also email comments about WellSense medical policies to medicalpolicy@wellsense.org. Please include the policy title and number with your comments.

WellSense network notifications and reimbursement policies are available at wellsense.org.

Medical Policy

Imlygic® (talimogene laherparepvec)

Policy Number: OCA 3.219
Version Number: 1
Version Effective Date: 10/01/24

Impacted Products

- ☐ **All Products**
- ☐ NH Clarity plans
- ☒ NH Medicaid
- ☒ NH Medicare Advantage
- ☒ MA MassHealth ACO
- ☒ MA MassHealth MCO
- ☒ MA Clarity plans
- ☒ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers Imlygic® (talimogene laherparepvec), a genetically modified oncolytic viral therapy by BioVex, Inc., medically necessary for the local treatment of unresectable cutaneous, subcutaneous, and nodal lesions in members with melanoma recurrent after initial surgery and Plan criteria are met. Plan prior authorization with Plan Medical Director review and approval is required.

Clinical Criteria

At the time of the Plan's most recent policy review, Imlygic® (talimogene laherparepvec) was listed on the MassHealth Drug List. The Plan uses MassHealth clinical review criteria to determine the medical necessity of this service when requested for MassHealth members. The MassHealth Drug List and clinical guidelines for Imlygic® (talimogene laherparepvec) are available at: MassHealth Drug List. If there is no guidance from MassHealth on the date of the prior authorization request, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

For all other Plan products, all criteria in items 1 through 4 must be met and documented:

1. Member has a confirmed diagnosis of unresectable cutaneous, subcutaneous, and nodal lesions with melanoma recurrence after initial surgery; AND

2. Member age ≥ 18 on the date of service; AND

3. Imlygic ® is prescribed by or in consultation with an oncologist; AND

4. Imlygic ® will be used according to FDA-approved guidelines and all treatment criteria are met in items a through e:

    a. Total treatment time will NOT exceed 18 consecutive months; AND

    b. Lesions clustered together will be injected as a single lesion; AND

    c. Initial dose will not exceed 4 mL at a concentration of 10^6 (1 million) plaque-forming units (PFU) per mL; AND

    d. Second dose will be administered ≥ 3 weeks and will not exceed 4 mL at a concentration of 10^8 (100 million) plaque-forming units (PFU) per mL: AND

    e. Subsequent doses will be administered ≥ 2 weeks and will not exceed 4 mL at a concentration of 10^8 (100 million) PFU per mL.

Limitations and Exclusions

1. Imlygic® (talimogene laherparepvec) is considered NOT medically necessary when treatment is provided to a member with any condition or treatment listed below due to limited evidence demonstrating the clinical utility, clinical validity, and safety of treatment:

    a. Members with any medical condition listed in items (1) through (5):

        (1) Active cerebral metastases;

        (2) Bone metastases;

        (3) Extensive visceral disease;

        (4) Primary ocular or mucosal melanoma; AND/OR

        (5) Evidence of immunocompromised condition, including but not limited to a history of primary or acquired immunodeficient states, leukemia, lymphoma, AIDS or other clinical manifestations of infection with human immunodeficiency viruses or is on immunosuppressive.

b. Member who are pregnant, considering pregnancy, or breastfeeding during treatment.

c. Member receiving treatment with acyclovir or other system antiherpetic viral agents.

d. Member age 17 or younger on the date of service.

2. Imlygic® is not medically necessary when Plan criteria are not met and/or not used according to FDA-approved guidelines.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for the Plan's Senior Care Options (SCO) members and New Hampshire Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, no applicable clinical guidelines were found from CMS for Imlygic® (talimogene laherparepvec). When there is no guidance from CMS for the requested service for the specified indication on the date of the prior authorization request, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. Since these codes may be updated at different intervals than the medical policy review cycle, the list of applicable codes included in a policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitations and Exclusions section of a medical policy, even if an applicable code appropriately describing the service is not included in the policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

HCPCS Code	**Description: Code Considered Medically Necessary When Billed with an ICD-10 Diagnosis Code Listed Below and Plan Criteria are Met**
J9325	Injection, talimogene laherparepvec, per 1 million plaque forming units

References

Adam J, Robertson J, Donegan E, Voicechovskaja I. NICE guidance for talimogene laherparepvec for unresectable metastatic melanoma. Volume 17, Issue 11, P1485-86. 2016 November.

Aldrak N, Alsaab S, Algethami A, Bhere D, Wakimoto H, Shah K, Alomary MN, Zaidan N. Oncolytic Herpes Simplex Virus-Based Therapies for Cancer. 2021 Jun; 10(6): 1541. doi: 10.3390/cells10061541. PMID: 34207386.

Andtbacka RH, Kaufman HL, Collichio F, Amatruda T, Senzer N, Chesney J, Delman KA, Spitler LE, Puzanov I, Agarwala SS, Milhem M, Cranmer L, Curti B, Lewis K, Ross M, Guthrie T, Linette GP, Daniels GA, Harrington K, Middleton MR, Miller Jr WH, Zager JS, Ye Y, Yao B, Li A, Doleman S, VanderWalde A, Gansert J, Coffin RS. Talimogene Laherparepvec Improves Durable Response Rate in Patients with Advanced Melanoma. J Clin Oncol. 2015 Sep 1;33(25):2780-8. doi: 10.1200/JCO.2014.58.3377. Epub 2015 May 26. PMID: 26014293.

BioVex, Inc. (a subsidiary of Amgen Inc.). IMLYGIC® (talimogene laherparepvec) Prescribing Information.

Coit DG, Thompson JA, Albertini MR, Barker C, Carson WE, Contreras C, Daniels GA, DiMaio D, Fields RC, Fleming MD, Freeman M, Galan A, Gastman B, Guild V, Johnson D, Joseph RW, Lange JR, Nath S, Olszanski AJ, Ott P, Gupta AP, Ross MI, Salama AK, Skitzki J, Sosman J, Swetter SM, Tanabe KK, Wuthrick E, McMillian NR, Engh AM. Cutaneous Melanoma, Version 2.2019, NCCN Clinical Practice Guidelines in Oncology. J Natl Compr Canc Netw. 2019 Apr 1;17(4):367-402. doi: 10.6004/jnccn.2019.0018. PMID: 30959471.

Dummer R, Gyorki DE, Hyngstrom J, Berger AC, Conry R, Demidov L, Sharma A, Treichel SA, Radcliffe H, Gorski KS, Anderson A, Chan E, Faries M, Ross MI. Neoadjuvant talimogene laherparepvec plus surgery versus surgery alone for resectable stage IIIB-IVM1a melanoma: a randomized, open-label, phase 2 trial. Nat Med. 2021 Oct;27(10):1789-96. doi: 10.1038/s41591-021-01510-7. Epub 2021 Oct 4. PMID: 34608333.

Ferrucci PF, Pala L, Conforti F, Cocorocchio E. Talimogene Laherparepvec (T-VEC): An Intralesional Cancer Immunotherapy for Advanced Melanoma. Cancers (Basel). 2021 Mar; 13(6): 1383. doi: 10.3390/cancers13061383. PMID: 33803762.

Franke V, Stahlie EHA, Klop WMC, Zuur CL, Berger DMS, van der Hiel B, van de Wiel BA, Wouters MWJM Winan , van Houdt WJ, van AkkooiACJ. Talimogene laherparepvec monotherapy for head and neck melanoma patients. Melanoma Res. 2023 Feb 1;33(1):66-70. doi: 10.1097/CMR.0000000000000866. Epub 2022 Nov 29. PMID: 36454284.

Haitz K, Khosravi H, Lin JY, Menge T, Nambudiri VE. Review of talimogene laherparepvec: A first-in-class oncolytic viral treatment of advanced melanoma. J Am Acad Dermatol . 2020 Jul;83(1):189-96. doi: 10.1016/j.jaad.2020.01.039. Epub 2020 Jan 28. PMID: 32004650.

Hu JC, Coffin RS, Davis CJ, Graham NJ, Groves N, Guest PJ, Harrington KJ, James ND, Love CA, McNeish IA, Medley LC, Michael A, Nutting CM, Pandha HS, Shorrock CA, Simpson J, Steiner J, Steven NM, Wright D, Coombes RC. A phase I study of OncoVEXGM-CSF, a second-generation

oncolytic herpes simplex virus expressing granulocyte macrophage colony-stimulating factor. Clin Cancer Res. 2006 Nov 15;12(22):6737-47. doi: 10.1158/1078-0432.CCR-06-0759. PMID: 17121894.

Johnson DB, Puzanov I, Kelley MC. Talimogene laherparepvec (T-VEC) for the treatment of advanced melanoma. Immunotherapy. 2015;7(6):611-9. doi: 10.2217/imt.15.35. Epub 2015 Jun 22. PMID: 26098919.

Kaufman HL, Shalhout SZ, Iodice G. Talimogene Laherparepvec: Moving From First-In-Class to Best-In-Class. Front Mol Biosci. 2022; 9: 834841. doi: 10.3389/fmolb.2022.834841. PMID: 35274007.

Korn EL, Liu PY, Lee SJ, Chapman JW, Niedzwiecki D, Suman VJ, Moon J, Sondak VK, Atkins MB, Eisenhauer EA, Parulekar W, Markovic SN, Saxman S, Kirkwood JM. Meta-analysis of phase II cooperative group trials in metastatic stage IV melanoma to determine progression-free and overall survival benchmarks for future phase II trials. J Clin Oncol. 2008 Feb 1;26(4):527-34. doi: 10.1200/JCO.2007.12.7837. PMID: 18235113.

Maverakis E, Cornelius LA, Bowen GM, Phan T, Patel FB, Fitzmaurice S, He Y, Burrall B, Christopher Duong, April M Kloxin, Hawa Sultani, Reason Wilken, Steve R Martinez, Forum Patel. Metastatic melanoma - a review of current and future treatment options. Acta Derm Venereol. 2015 May;95(5):516-24. doi: 10.2340/00015555-2035. PMID: 25520039.

Michielin O, van Akkiil ACJ, Dummer R, Keilholz**.** Cutaneous melanoma: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. Volume 30, Issue 12, P1884-1901. 2019 December.

National Cancer Institute (NCI). Melanoma treatment – for health professionals (PDQ®). Updated 2016 February 02.

National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology. Cutaneous Melanoma, Version 2.2019.

Niezgoda A, Niezgoda P, Czajkowski R. Novel Approaches to Treatment of Advanced Melanoma: A Review on Targeted Therapy and Immunotherapy. Biomed Res Int. 2015;2015:851387. doi: 10.1155/2015/851387. Epub 2015 Jun 10. PMID: 26171394.

Pol J, Bloy N, Obrist F, Eggermont A, Galon J, Cremer I, Erbs P, Limacher J, Preville X, Zitvogel L, Kroemer G, Galluzzi L. Trial Watch:: Oncolytic viruses for cancer therapy. Oncoimmunology. 2014 Jun 1;3:e28694. doi: 10.4161/onci.28694. eCollection 2014. PMID: 25097804.

Rehman H, Silk AW, Kane MP, Kaufman HL. Into the clinic: Talimogene laherparepvec (T-VEC), a first-in-class intratumoral oncolytic viral therapy. J Immunother Cancer. 2016; 4: 53 doi: 10.1186/s40425-016-0158-5. PMID: 27660707.

Scott LJ. Nivolumab: A Review in Advanced Melanoma. Drugs. 2015 Aug;75(12):1413-24. doi: 10.1007/s40265-015-0442-6. PMID: 26220912.

Senzer NN, Kaufman HL, Amatruda T, Nemunaitis M, Reid T, Daniels G, Gonzalez R, Glaspy J, Whitman E, Harrington K, Goldsweig H, Marshall T, Love C, Coffin R, Nemunaitis JJ. Phase II clinical trial of a granulocyte-macrophage colony-stimulating factor-encoding, second-generation oncolytic herpesvirus in patients with unresectable metastatic melanoma. J Clin Oncol. 2009 Dec 1;27(34):5763-71. doi: 10.1200/JCO.2009.24.3675. Epub 2009 Nov 2. PMID: 19884534.

Siegel RL, Miller KD, Jemal A. Cancer statistics, 2015. CA Cancer J Clin. 2015 Jan-Feb;65(1):5-29. doi: 10.3322/caac.21254. Epub 2015 Jan 5. PMID: 25559415.

U. S. Food and Drug Administration (FDA). IMLYGIC® (talimogene laherparepvec) Suspension for intralesional injection Imlygic. Package insert. Initial U.S. Approval: 2015.

Zhang T, Jou TH, Hsin J, Wang Z, Huang K, Ye J, Yin H, Xing Y. Talimogene Laherparepvec (T-VEC): A Review of the Recent Advances in Cancer Therapy. J Clin Med. 2023 Feb; 12(3): 1098. doi: 10.3390/jcm12031098. PMID: 36769745.

Next Review Date

07/01/25

Authorizing Entity

UMC

Appendix

Appendix: Policy History

Disclaimer Information:
Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date and Version	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 07/19/24	10/01/24 Version 1	Senior Medical Director as Chair of Utilization Management Committee (UMC)	UMC

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
N/A	N/A	N/A	N/A

Medical Policy

Laviv® (azficel-T)

Policy Number: OCA 3.220
Version Number: 1
Version Effective Date: 10/01/24

Impacted Products

- ☐ **All Products**
- ☐ NH Clarity plans
- ☒ NH Medicaid
- ☒ NH Medicare Advantage
- ☒ MA MassHealth ACO
- ☒ MA MassHealth MCO
- ☒ MA Qualified Health Plans/Employer Choice Direct
- ☒ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers the use of Laviv® (azficel-T), an autologous cellular product typically administered in an outpatient setting, NOT medically necessary as restorative or reconstructive treatment. Laviv® (azficel-T) is used to improve the appearance of moderate to severe nasolabial fold wrinkles in adults, and the Plan considers this treatment cosmetic for any other indication. Plan prior authorization is required. Review the Plan's *Cosmetic, Reconstructive, and Restorative Services* medical policy, policy number OCA 3.69, for the product-specific definitions of cosmetic, reconstructive, and restorative services.

Clinical Criteria

See the Limitations and Exclusions section.

At the time of the Plan's most recent policy review, no applicable MassHealth clinical guidelines were found for Laviv® (azficel-T) on either the MassHealth Drug List or the MassHealth Acute Hospital Carve-Out Drugs List. Verify MassHealth criteria in effect on the date of the prior authorization request for a MassHealth member. When there is no guidance from MassHealth on the date of the prior authorization request, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service. Drugs listed on the MassHealth Acute Hospital Care-Out Drugs list are

subject to additional MassHealth monitoring and billing requirements for MassHealth members, and Utilization Reviewers will reach out to providers approximately 30 calendar days after the treatment to verify the clinical effective of treatment and at ongoing intervals for long-term monitoring of sustained response.

Limitations and Exclusions

The Plan considers the use of Laviv® (azficel-T) to be cosmetic and NOT medically necessary as a restorative treatment when used to improve the appearance of moderate to severe nasolabial fold wrinkles in adults or for any other indication, even when used according to FDA-approved guidelines.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for the Plan's Senior Care Options (SCO) members and New Hampshire Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, no applicable clinical guidelines were found from CMS on the use of Laviv® (azficel-T). Verify CMS criteria in effect for the requested service on the date of the prior authorization request for a SCO or New Hampshire Medicare Advantage HMO member. When there is no guidance from CMS for the requested service for the specified indication on the date of the prior authorization request, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. Since these codes may be updated at different intervals than the medical policy review cycle, the list of applicable codes included in a policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitations and Exclusions section of a medical policy, even if an applicable code appropriately describing the service is not included in the policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

HCPCS Code	Description: Codes Covered When Medically Necessary
J3590	Unclassified biologics Plan note: No treatment-specific code is assigned to Laviv® (azficel-T).

ICD-10 Diagnosis Code	Description: Diagnosis code considered medically necessary when billed with the HCPCS code listed above and Plan criteria are met
L90.8	Other atrophic disorders of skin [nasolabial fold wrinkles]

References

Fibrocell Technologies, Inc. Laviv (Azficel-T).

Munavalli GS, Smith S, Maslowski JM, Weiss RA. Successful treatment of depressed, distensible acne scars using autologous fibroblasts: a multi-site, prospective, double blind, placebo-controlled clinical trial. Dermatol Surg. 2013 Aug;39(8):1226-36. doi: 10.1111/dsu.12204. Epub 2013 Apr 8. PMID: 23566237.

Smith SR, Munavalli G, Weiss R, Maslowski JM, Hennegan KP, Novak JM. A multicenter, double-blind, placebo-controlled trial of autologous fibroblast therapy for the treatment of nasolabial fold wrinkles. Dermatol Surg. 2012 Jul;38(7 Pt 2):1234-43. doi: 10.1111/j.1524-4725.2012.02349.x. Epub 2012 Mar 12. PMID: 22409385.

U.S. Food and Drug Administration (FDA). LAVIV® (azficel-T). Package Insert. Revised 2011 Jun.

Wanitphakdeedecha R, Ng JNC, Phumariyapong P, Nokdhes YN, Patthamalai P, Tantrapornpong P, Suphatsathienkul P, Apinuntham C, Yan C, Nanchaipruek Y, Thongjaroensirikul P, Maneeprasopchoke P, Techapichetvanich T, Eimpunth S, Manuskiatti W, Thanachaipiwat S, Panich U. A pilot study comparing the efficacy of autologous cultured fibroblast injections with hyaluronic acid fillers for treating nasolabial folds. Sci Rep. 2023 Apr 24;13(1):6616. doi: 10.1038/s41598-023-33786-9. PMID: 37095274.

Next Review Date

07/01/25

Authorizing Entity

UMC

Appendix

Appendix: Policy History

Disclaimer Information:

Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity

definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement. Appendix: Policy History

Original Approval Date	Original Effective Date and Version	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 07/17/24	06/01/24 Version 1	Senior Medical Director as Chair of Utilization Management Committee (UMC)	UMC

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
N/A	N/A	N/A	N/A

Medical Policy

Zolgensma® (onasemnogene abeparvovec)

Policy Number: OCA 3.213
Version Number: 1
Version Effective Date: 10/01/24

Impacted Products

- ☐ **All Products**
- ☐ NH Clarity plans
- ☒ NH Medicaid
- ☒ NH Medicare Advantage
- ☐ MA MassHealth ACO
- ☐ MA MassHealth MCO
- ☒ MA Clarity plans/Employer Choice Direct
- ☒ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers Zolgensma® (onasemnogene abeparvovec), an adeno-associated virus vector-based gene therapy by Novartis Gene Therapies, medically necessary to treat pediatric members with spinal muscular atrophy (SMA) when Plan criteria are met. Plan prior authorization with Plan Medical Director review and approval is required. Review the Plan's *Gene Therapy and Cell Therapy Included on MassHealth Acute Hospital Carve-Out Drugs List* medical policy, policy number OCA 3.23, for guidelines applicable for the Plan's MassHealth members.

Clinical Criteria

Zolgensma® (onasemnogene abeparvovec) is considered medically necessary when all applicable criteria in items 1 through 5 are met and documented:

1. Member meets all criteria in items a through g:

   a. Genetically confirmed diagnosis of spinal muscular atrophy (SMA), with documentation of bi-allelic mutations in the survival motor neuron 1 (SMN1) gene; AND

   b. < 2 years of age on the date of service; AND

c. Full term gestational age has been reached; AND

d. Body weight is ≥ 2.6 kg and ≤ 21.0 kg; AND

e. Anti-adeno-associated virus 9 (AAV9) antibody titer less than or equal to 1:50 measured with enzyme-linked immunosorbent assay (ELISA); AND

f. Has not previously received gene therapy, including Zolgensma®; AND

2. Zolgensma® (onasemnogene abeparvovec) will be used according to FDA-approved guidelines; AND

3. Prescriber is a neurologist or consultation notes from a neurologist are provided; AND

4. One-time, single-dose treatment will be administered at a designated Zolgensma® treatment center; AND

5. Prior to administration and after, systemic corticosteroids will be administered; AND

6. Treating provider has determined that the member is clinically stable in overall baseline health status prior to infusion (e.g., hydration and nutritional status, absence of infection, platelet counts, troponin-I) with assessment by clinical examination and laboratory testing by the treating provider that includes but is not limited to liver function tests (due to risk of liver injury) according to FDA-approved treatment protocol for Zolgensma®.

Limitations and Exclusions

Any of the following services is considered NOT medically necessary due to insufficient evidence demonstrating the clinical utility and/or clinical validity of treatment:

1. Repeat treatment with Zolgensma® (onasemnogene abeparvovec) for a Plan member (with treatment limited to once per lifetime, including use in a clinical trial or while insured under another health plan).

2. Zolgensma® (onasemnogene abeparvovec) when Plan criteria are not met and/or not used according to FDA-approved guidelines.

3. Treatment with Zolgensma® (onasemnogene abeparvovec) for a member with advanced SMA (e.g., complete paralysis of limbs; permanent ventilator dependence; or respiratory assistance for 16 or more hours per day, including noninvasive ventilatory support, continuously for 14 or more days in the absence of an acute reversible illness and excludes perioperative ventilation).

4. Antepartum use has not been evaluated in clinical trials.

5. Contraindications to treatment with Zolgensma® (onasemnogene abeparvovec) include a member that is not clinically stable in their overall baseline health status (e.g., hydration and nutritional status, absence of infection) prior to infusion of Zolgensma®. Treatment with Zolgensma® should be postponed until infection is resolved and member is clinically stable.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for the Plan's Senior Care Options (SCO) members and New Hampshire Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, no applicable clinical guidelines were found from CMS on the use of Zolgensma® (onasemnogene abeparvovec). Verify CMS criteria in effect for the requested service on the date of the prior authorization request for a SCO or New Hampshire Medicare Advantage HMO member. When there is no guidance from CMS for the requested service for the specified indication on the date of the prior authorization request, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. Since these codes may be updated at different intervals than the medical policy review cycle, the list of applicable codes included in a policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitations and Exclusions section of a medical policy, even if an applicable code appropriately describing the service is not included in the policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

When Zolgensma® (onasemnogene abeparvovec) is a covered service for the Plan member, the treatment is considered medically necessary when clinical review criteria are met, prior authorization is obtained, and treatment is billed with the HCPCS code listed below. For MassHealth members, review the Plan's Gene Therapy and Cell Therapy Included on MassHealth Acute Hospital Carve-Out Drugs List medical policy, policy number OCA 3.23, for clinical, coding, and billing guidelines applicable for the Plan's MassHealth members.

HCPCS Code	Description: Code considered medically necessary when Plan criteria are met
J3399	Injection, onasemnogene abeparvovec-xioi, per treatment, up to $5x10^{15}$ vector genomes

References

Al-Zaidy S, Pickard AS, Kotha K, Alfano LN, Lowes L, Paul G, Church K, Lehman K, Sproule DM, Dabbous O, Maru B, Berry K, Arnold WD, Kissel JT, Mendell JR, Shell R. Health outcomes in spinal muscular atrophy type 1 following AVXS-101 gene replacement therapy. Pediatr Pulmonol. 2019 Feb;54(2):179-85. doi: 10.1002/ppul.24203. Epub 2018 Dec 12. PMID: 30548438.

Al-Zaidy SA, Kolb SJ, Lowes L, Alfano LN, Shell R, Church KR, Nagendran S, Sproule DM, Feltner DE, Wells C, Ogrinc F, Menier M, L'Italien J, Arnold WD, Kissel JT, Kaspar BK, Mendell JR. AVXS-101 (Onasemnogene Abeparvovec) for SMA1: Comparative Study with a Prospective Natural History Cohort. J Neuromuscul Dis. 2019;6(3):307-17. doi: 10.3233/JND-190403. PMID: 31381526.

Al-Zaidy SA, Mendell JR. From Clinical Trials to Clinical Practice: Practical Considerations for Gene Replacement Therapy in SMA Type 1. Pediatr Neurol. 2019 Nov;100:3-11. doi: 10.1016/j.pediatrneurol.2019.06.007. Epub 2019 Jun 13. PMID: 31371124.

Beecham GB, Tackling G. Peripheral Line Placement. Treasure Island (FL): StatPearls Publishing; 2023 Jan. Last Updated: 2022 July 25.

Bodamer OA. Spinal muscular atrophy. UpToDate. 2023 Apr 12.

Dabbous O, Maru B, Jansen JP, Lorenzi M, Cloutier M, Guérin A, Pivneva I, Wu EQ, Arjunji R, Feltner D, Sproule DM. Survival, Motor Function, and Motor Milestones: Comparison of AVXS-101 Relative to Nusinersen for the Treatment of Infants with Spinal Muscular Atrophy Type 1. Adv Ther. 2019 May;36(5):1164-76. doi: 10.1007/s12325-019-00923-8. Epub 2019 Mar 16. PMID: 30879249.

Darras BT. Spinal muscular atrophies. Pediatr Clin North Am. 2015 Jun;62(3):743-66. doi: 10.1016/j.pcl.2015.03.010. Epub 2015 Apr 11. PMID: 26022173.

Day JW, Finkel RS, Mercuri E, Swoboda KJ, Menier M, Olden RV, Tauscher-Wisniewski S, Mendell JR. Adeno-associated virus serotype 9 antibodies in patients screened for treatment with onasemnogene abeparvovec. Mol Ther Methods Clin Dev. 2021 Jun 11; 21: 76–82. doi: 10.1016/j.omtm.2021.02.014. PMID: 33768131.

Farrar MA, Park SB, Vucic S, Carey KA, Turner BJ, Gillingwater TH, Swoboda KJ, Kiernan MC. Emerging therapies and challenges in spinal muscular atrophy. Ann Neurol. 2017 Mar;81(3):355-68. doi: 10.1002/ana.24864. Epub 2017 Feb 17. PMID: 28026041.

Finkel RS, Mercuri E, Darras BT, Connolly AM, Kuntz NL, Kirschner J, Chiriboga CA, Saito K, Servais L, Tizzano E, Topaloglu H, Tulinius M, Montes J, Glanzman AM, Bishop K, Zhong ZJ, Gheuens S, Bennett CF, Schneider E, Farwell W, De Vivo DC; ENDEAR Study Group. Nusinersen versus Sham Control in Infantile-Onset Spinal Muscular Atrophy. N Engl J Med. 2017 Nov 2;377(18):1723-32. doi: 10.1056/NEJMoa1702752. PMID: 29091570.

Gyngell C, Stark Z, Savulescu J. Drugs, genes and screens: The ethics of preventing and treating spinal muscular atrophy. Bioethics. 2020 Jun;34(5):493-501. doi: 10.1111/bioe.12695. Epub 2019 Nov 26. PMID: 31770817.

Hayes. Precision Therapy Assessment. Onasemnogene Abeparvovec-xioi (Zolgensma) for Spinal Muscular Atrophy. Jul 29, 2020. Updated Sep 14, 2021.

Hensel N, Kubinski S, Claus P. The Need for SMN-Independent Treatments of Spinal Muscular Atrophy (SMA) to Complement SMN-Enhancing Drugs. Front Neurol. 2020; 11: 45. doi: 10.3389/fneur.2020.00045. PMID: 32117013.

Institute for Clinical and Economic Review (ICER). An assessment of Onasemnogene Abeparvovec and Nusinersen for Spinal Muscular Atrophy (SMA). 2019 Apr 3. Updated 2019 May 24. Confidential Data Unmasked 2020 Nov 2.

Kolb SJ, Coffey CS, Yankey JW, Krosschell K, Arnold WD, Rutkove SB, Swoboda KJ, Reyna SP, Sakonju A, Darras BT, Shell R, Kuntz N, Castro D, Iannaccone ST, Parsons J, Connolly AM, Chiriboga CA, McDonald C, Burnette WB, Werner K, Thangarajh M, Shieh PB, Finanger E, Cudkowicz ME, McGovern MM, McNeil DE, Finkel R, Kaye E, Kingsley A, Renusch SR, McGovern VL, Wang X, Zaworski PG, Prior TW, Burghes AHM, Bartlett A, Kissel JT. Baseline results of the NeuroNEXT spinal muscular atrophy infant biomarker study. Ann Clin Transl Neurol. 2016 Jan 21;3(2):132-45. doi: 10.1002/acn3.283. eCollection 2016 Feb. PMID: 26900585.

Kolb SJ, Coffey CS, Yankey JW, Krosschell K, Arnold WD, Rutkove SB, Swoboda KJ, Reyna SP, Sakonju A, Darras BT, Shell R, Kuntz N, Castro D, Parsons J, Connolly AM, Chiriboga CA, McDonald C, Burnette WB, Werner K, Thangarajh M, Shieh PB, Finanger E, Cudkowicz ME, McGovern MM, McNeil DE, Finkel R, Iannaccone ST, Kaye E, Kingsley A, Renusch SR, McGovern VL, Wang X, Zaworski PG, Prior TW, Burghes AHM, Bartlett A, Kissel JT. Natural history of infantile-onset spinal muscular atrophy. Ann Neurol. 2017 Dec;82(6):883-91. doi: 10.1002/ana.25101. Epub 2017 Dec 8. PMID: 29149772.

Kolb SJ, Kissel JT. Spinal Muscular Atrophy. Neurol Clin. 2015 Nov;33(4):831-46. doi: 10.1016/j.ncl.2015.07.004. PMID: 26515624.

Lowes LP, Alfano LN, Arnold WD, Shell R, Prior TW, McColly M, Lehman KJ, Church K, Sproule DM, Nagendran S, Menier M, Feltner DE, Wells C, Kissel JT, Al-Zaidy S, Mendell J. Impact of Age and Motor Function in a Phase 1/2A Study of Infants With SMA Type 1 Receiving Single-Dose Gene Replacement Therapy. Pediatr Neurol. 2019 Sep;98:39-45. doi: 10.1016/j.pediatrneurol.2019.05.005. Epub 2019 May 13. PMID: 31277975.

Malone DC, Dean R, Arjunji R, Jensen I, Cyr P, Miller B, Maru B, Sproule DW, Feltner DE, Dabbous O. Cost-effectiveness analysis of using onasemnogene abeparvocec (AVXS-101) in spinal muscular atrophy type 1 patients. J Mark Access Health Policy. 2019 May 8;7(1):1601484. doi: 10.1080/20016689.2019.1601484. eCollection 2019. PMID: 31105909.

Mendell JR, Al-Zaidy S, Shell R, Arnold WD, Rodino-Klapac LR, Prior TW, Lowes L, Alfano L, Berry K, Church K, Kissel JT, Nagendran S, L'Italien J, Sproule DM, Wells C, Cardenas JA, Heitzer MD, Kaspar A, Corcoran S, Braun L, Likhite S, Miranda C, Meyer K, Foust KD, Burghes AMH, Kaspar BK. Single-Dose Gene-Replacement Therapy for Spinal Muscular Atrophy. N Engl J Med. 2017 Nov 2;377(18):1713-22. doi: 10.1056/NEJMoa1706198. PMID: 29091557.

National Health Service (NHS). Treatment Spinal muscular atrophy. Page last reviewed: 2020 May 04. Next review due: 2023 May 04.

National Institute for Health and Care Excellence (NICE). Onasemnogene abeparvovec for treating spinal muscular atrophy. Highly specialized technologies guidance. Reference number: HST15. Published: 2021 Jul 07. Last Updated: 2023 Apr 19.

National Institute of Neurological Disorders and Stroke (NINDS). Spinal Muscular Atrophy. Last Reviewed 2023 March 13.

Nuijten M. Pricing Zolgensma – the world's most expensive drug. J Mark Access Health Policy. 2022; 10(1):2022353. doi: 10.1080/20016689.2021.2022353. PMID: 34992762.

Ogbonmide O, Rathore R, Rangrej SB, Hutchinson S, Lewis M, Ojilere S, Carvalho V, Kelly I. Gene Therapy for Spinal Muscular Atrophy (SMA): A Review of Current Challenges and Safety Considerations for Onasemnogene Abeparvovec (Zolgensma). Cureus. 2023 Mar;15(3):e36197. doi: 10.7759/cureus.36197. PMID: 37065340.

Online Mendelian Inheritance in Man (OMIM). SMA, Infantile Acute Form Muscular Trophy, Infantile Werding-Hoffman Disease.

Shorrock HK, Gillingwater TH, Groen EJN. Overview of Current Drugs and Molecules in Development for Spinal Muscular Atrophy Therapy. Drugs. 2018 Mar;78(3):293-305. doi: 10.1007/s40265-018-0868-8. PMID: 29380287.

Stevens D, Claborn MK, Gildon BL, Kessler TL, Walker C. Onasemnogene Abeparvovec-xioi: Gene Therapy for Spinal Muscular Atrophy. Ann Pharmacother. 2020 Oct;54(10):1001-9. doi: 10.1177/1060028020914274. Epub 2020 Mar 23. PMID: 32204605.

U. S. Food and Drug Administration (FDA). ZOLGENSMA®. Package Insert. Initial Approval: 2019. Revised 2023 Feb.

Verhaart IEC, Robertson A, Wilson IJ, Aartsma-Rus A, Cameron S, Jones CC, Cook SF, Lochmüller H. Prevalence, incidence and carrier frequency of 5q-linked spinal muscular atrophy - a literature review. Orphanet J Rare Dis. 2017 Jul 4;12(1):124. doi: 10.1186/s13023-017-0671-8. PMID: 28676062.

Waldrop MA, Kolb SJ. Current Treatment Options in Neurology-SMA Therapeutics. Curr Treat Options Neurol. 2019 Apr 29;21(6):25. doi: 10.1007/s11940-019-0568-z. PMID: 31037425.

Next Review Date

07/01/25

Authorizing Entity

UMC

Appendix

Appendix: Policy History

Disclaimer Information:
Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date and Version	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 07/17/24	10/01/24 Version 1	Senior Medical Director as Chair of Utilization Management Committee (UMC)	UMC

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
N/A	N/A	N/A	N/A