Qalsody (tofersen)
PAM – 075

Iowa Medicaid Program	Prior Authorization	**Effective Date**	10/01/2023
Revision Number	2	**Last Reviewed**	04/18/2025
Reviewed By	Medicaid Medical Director	**Next Review**	04/17/2026
Approved By	Medicaid Clinical Advisory Committee	**Approved Date**	04/19/2024

Overview

Medication: [1]	tofersen
Brand Name:	Qalsody®
Pharmacologic Category:	antisense oligonucleotide (ASO)
FDA-Approved Indication(s):	Indicated for the treatment of amyotrophic lateral sclerosis (ALS) in adults who have a mutation in the superoxide dismutase 1 (SOD1) gene. ▶ Accelerated Approval: This indication is approved under accelerated approval based on reduction in plasma neurofilament light chain (NfL) observed in patients treated with Qalsody®. Continued approval for this indication may be contingent upon verification of clinical benefit in confirmatory trial(s).
How Supplied:	Single-dose vial, 100 mg/15 mL
Dosage and Administration:	• Must be administered by, or under the direction of, healthcare professionals experienced in performing lumbar punctures • Dose is 100 mg (15 mL) per intrathecal administration ○ Administer three (3) loading doses at 14-day intervals; then, ○ Administer a maintenance dose every 28 days thereafter
Benefit Category:	Medical

Descriptive Narrative

Amyotrophic lateral sclerosis (ALS), commonly known as Lou Gehrig's disease, is a progressive, presently incurable neurodegenerative disorder that causes muscle weakness, disability, and eventually death. ALS is the most common form of acquired motor neuron disease. Clinical manifestations of ALS include the presence of upper motor neuron and lower motor neuron signs, progression of disease, and the absence of an alternative explanation.[2]

ALS has an annual incidence of one to three cases per 100,000 people. There does not appear to be any ethnic or racial disposition to ALS. Prior to 65 to 70 years of age, the incidence of ALS is higher in males than females, but thereafter the gender incidence is equal. ALS has an age distribution that peaks in the

seventh to eighth decades. However, ALS can occur in people in their twenties. ALS is most commonly sporadic. Genetic or familial ALS represents only 10 percent of all ALS.[3]

Diagnostic criteria for amyotrophic lateral sclerosis (ALS) – comparison

There is no single diagnostic test that can confirm or entirely exclude the diagnosis of motor neuron disease. A consensus meeting was convened in 2019 (Gold Coast, Australia, 2019) to consider the development of simpler criteria that better reflect clinical practice and that could merge diagnostic categories into a single entity.[4] A comparison of the criteria is shown below.

Category*	Revised El Escorial (or Arlie House) criteria (2005)[5]	Awaji criteria** (2008)[6]	Gold Coast criteria*** (2019)[7]
Presence of ALS	Different diagnostic categories (see below)	Different diagnostic categories (see below)	Progressive motor impairment documented by history or repeated clinical assessment, preceded by normal motor function, **AND** Presence of UMN and LMN dysfunction in at least one body region, **OR** LMN dysfunction in at least two body regions, **AND** Investigations excluding other disease processes
Definite ALS	UMN and LMN signs in three spinal regions, **OR** Bulbar region and two spinal regions	UMN and LMN signs in three spinal regions, **OR** Bulbar region and two spinal regions	Abolished
Probable ALS	UMN and LMN signs in at least two regions with some UMN signs necessarily rostral to (above) the LMN signs	UMN and LMN signs in at least two regions with some UMN signs necessarily rostral to (above) the LMN signs	Abolished
Clinically probable ALS: laboratory-supported	UMN and LMN signs in one region, **OR** UMN signs alone present in one region, and LMN signs defined by EMG criteria present in at least two regions	Category abolished	
Possible ALS	UMN and LMN signs in one region, **OR** UMN signs in two or more regions; **OR** LMN signs are found rostral to UMN signs and the diagnosis of clinically probable ALS-laboratory supported cannot be proven		Abolished

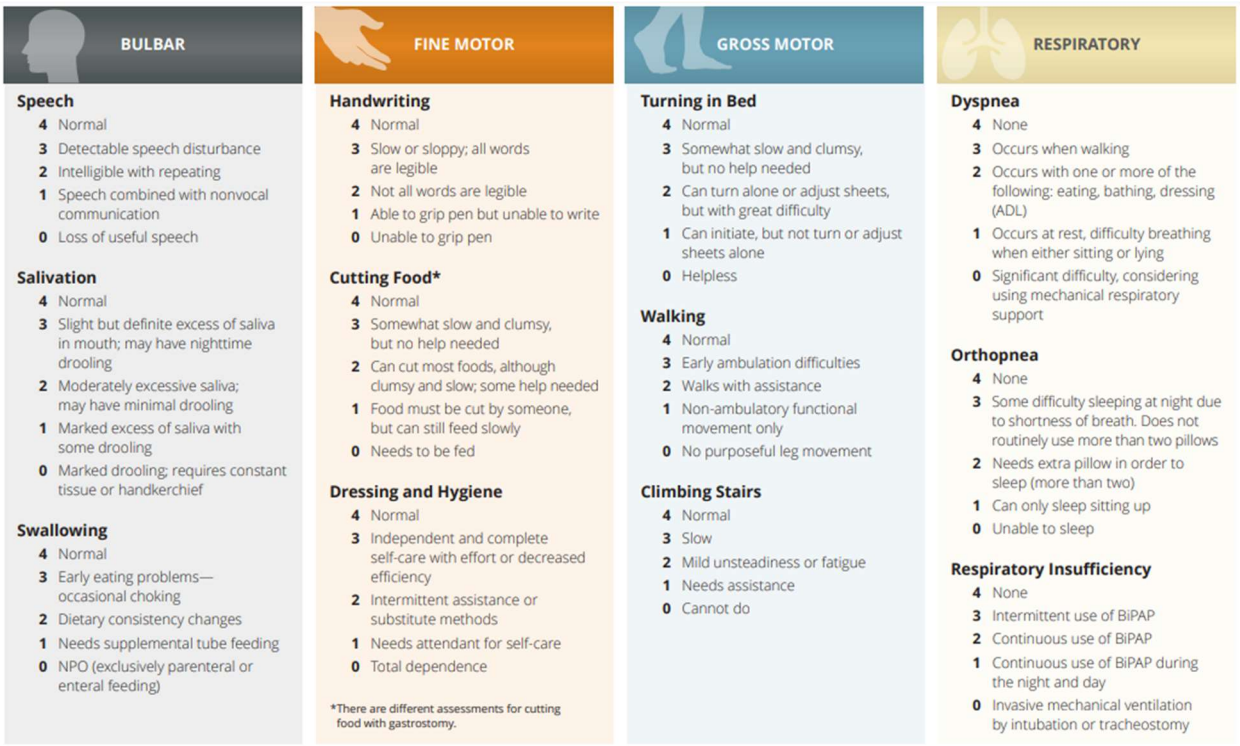
* Abbreviations: **ALS:** amyotrophic lateral sclerosis; **LMN:** lower motor neuron; **UMN:** upper motor neuron

** For Awaji criteria, LMN dysfunction was defined by clinical, electrophysiological, or neuropathological examination. Fasciculation potentials were regarded equivalent to ongoing changes (fibrillation potentials and positive sharp waves) in the presence of chronic neurogenic changes.

*** For Gold Coast criteria, LMN dysfunction was defined clinically or by electrophysiological assessment. Diagnostic categories were excluded in the Gold Coast criteria.

Amyotrophic Lateral Sclerosis (ALS) Functional Rating Scale – Revised (ALSFRS-R)

The ALSFRS-R measures progression of disability in people with amyotrophic lateral sclerosis (ALS).[8] Scores decline with disease progression at a rate that is generally consistent across clinical trials. The original ALSFRS was revised in 1999 to balance respiratory with limb and bulbar categories. The ALSFRS-R measures 12 aspects of physical function, ranging from one's ability to swallow and use utensils to climbing stairs and breathing. Each function is scored from 0 to 4, with higher scores representing greater functional ability.



BULBAR

Speech
- 4 Normal
- 3 Detectable speech disturbance
- 2 Intelligible with repeating
- 1 Speech combined with nonvocal communication
- 0 Loss of useful speech

Salivation
- 4 Normal
- 3 Slight but definite excess of saliva in mouth; may have nighttime drooling
- 2 Moderately excessive saliva; may have minimal drooling
- 1 Marked excess of saliva with some drooling
- 0 Marked drooling; requires constant tissue or handkerchief

Swallowing
- 4 Normal
- 3 Early eating problems—occasional choking
- 2 Dietary consistency changes
- 1 Needs supplemental tube feeding
- 0 NPO (exclusively parenteral or enteral feeding)

FINE MOTOR

Handwriting
- 4 Normal
- 3 Slow or sloppy; all words are legible
- 2 Not all words are legible
- 1 Able to grip pen but unable to write
- 0 Unable to grip pen

Cutting Food*
- 4 Normal
- 3 Somewhat slow and clumsy, but no help needed
- 2 Can cut most foods, although clumsy and slow; some help needed
- 1 Food must be cut by someone, but can still feed slowly
- 0 Needs to be fed

Dressing and Hygiene
- 4 Normal
- 3 Independent and complete self-care with effort or decreased efficiency
- 2 Intermittent assistance or substitute methods
- 1 Needs attendant for self-care
- 0 Total dependence

*There are different assessments for cutting food with gastrostomy.

GROSS MOTOR

Turning in Bed
- 4 Normal
- 3 Somewhat slow and clumsy, but no help needed
- 2 Can turn alone or adjust sheets, but with great difficulty
- 1 Can initiate, but not turn or adjust sheets alone
- 0 Helpless

Walking
- 4 Normal
- 3 Early ambulation difficulties
- 2 Walks with assistance
- 1 Non-ambulatory functional movement only
- 0 No purposeful leg movement

Climbing Stairs
- 4 Normal
- 3 Slow
- 2 Mild unsteadiness or fatigue
- 1 Needs assistance
- 0 Cannot do

RESPIRATORY

Dyspnea
- 4 None
- 3 Occurs when walking
- 2 Occurs with one or more of the following: eating, bathing, dressing (ADL)
- 1 Occurs at rest, difficulty breathing when either sitting or lying
- 0 Significant difficulty, considering using mechanical respiratory support

Orthopnea
- 4 None
- 3 Some difficulty sleeping at night due to shortness of breath. Does not routinely use more than two pillows
- 2 Needs extra pillow in order to sleep (more than two)
- 1 Can only sleep sitting up
- 0 Unable to sleep

Respiratory Insufficiency
- 4 None
- 3 Intermittent use of BiPAP
- 2 Continuous use of BiPAP
- 1 Continuous use of BiPAP during the night and day
- 0 Invasive mechanical ventilation by intubation or tracheostomy

Guidelines

Current practice guidelines for care of the patient with ALS from the American Academy of Neurology were published in 2009 and reaffirmed in 2020.[9,10]

- Practice parameter update: The care of the patient with amyotrophic lateral sclerosis: drug, nutritional, and respiratory therapies (an evidence-based review): Report of the Quality Standards Subcommittee of the American Academy of Neurology.
- Practice parameter update: The care of the patient with amyotrophic lateral sclerosis: multidisciplinary care, symptom management, and cognitive/behavioral impairment (an evidence-based review): Report of the Quality Standards Subcommittee of the American Academy of Neurology.

Criteria

Prior authorization is required.

Qalsody® is considered medically necessary when **ALL** of the following are met:

1. Diagnosis of amyotrophic lateral sclerosis (ALS) with **BOTH** of the following (a and b):
    a. Documentation of mutation in the superoxide dismutase 1 (SOD1) gene; **AND**
    b. Muscle weakness associated with ALS; **AND**
2. Member is 18 years of age or older; **AND**
3. Prescribed by, or in consultation with, a neurologist, neuromuscular specialist, or physician specializing in the treatment of amyotrophic lateral sclerosis (ALS); **AND**
4. Request meets one of the following (a or b):
    a. Regimen prescribed does not exceed loading dose regimen of 100 mg on days 1, 15, and 29, followed by 100 mg (1 vial) every 28 days; or
    b. Regimen is supported by clinical practice guidelines. Supporting clinical documentation must be provided with any request for which regimen prescribed does not align with FDA-approved labeling.

Qalsody® is considered medically necessary for continuation of therapy when **ALL** of the following are met:

1. Member is currently receiving medication through the Iowa Medicaid benefit or has previously met initial approval criteria; **AND**
2. Member does not require invasive ventilation or tracheostomy; **AND**
3. Prescribed by, or in consultation with, a neurologist, neuromuscular specialist, or physician specializing in the treatment of amyotrophic lateral sclerosis (ALS); **AND**
4. Request meets one of the following (a or b):
    a. Regimen prescribed does not exceed 100 mg (1 vial) every 28 days; or
    b. Regimen is supported by clinical practice guidelines. Supporting clinical documentation must be provided with any request for which regimen prescribed does not align with FDA-approved labeling.

Approval Duration and Quantity Limits

	Initial Authorization	Subsequent Authorization(s)
Approval Duration	6 months	12 months
Quantity Limits	• Loading dose: 100 mg on days 1, 15, and 29 • Maintenance: 100 mg (1 vial) every 28 days	100 mg (1 vial) every 28 days

Coding and Product Information

The following list(s) of codes and product information are provided for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment, nor does the exclusion of a code imply that its association to the HCPCS code is inappropriate.

HCPCS	Description
~~C9157~~	~~Injection, tofersen, 1 mg~~ *(effective 10/1/2023 – 12/31/2023)*
J1304	Injection, tofersen, 1 mg *(effective 01/01/2024)*

ICD-10	Description
G12.21	Amyotrophic lateral sclerosis

NDC (Strength)	Labeler	Dosage	Pkg Size	Pkg Qty	Units/ Pkg
64406-0109-01 [single-dose vial: 100 mg/15 mL (6.7 mg/mL)]	Biogen MA Inc. (64406)	1 mg	1	EA	100

Compliance

1. Should conflict exist between the policy and applicable statute, the applicable statute shall supersede.
2. Federal and State law, as well as contract language, including definitions and specific contract provisions or exclusions, take precedence over medical policy and must be considered first in determining eligibility for coverage.
3. Medical technology is constantly evolving, and Iowa Medicaid reserves the right to review and update medical policy on an annual or as-needed basis.

Medical necessity guidelines have been developed for determining coverage for member benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. Medical necessity guidelines are developed for selected physician-administered medications found to be safe and proven to be effective in a limited, defined population or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Criteria are revised and updated annually, or more frequently if new evidence becomes available that suggests needed revisions.

References

[1] Qalsody® prescribing information (04/2023). Biogen MA Inc.: Cambridge, MA. Available online: www.qalsodyhcp.com. Accessed March 5, 2025.

[2] Elman L, McCluskey L. Diagnosis of amyotrophic lateral sclerosis and other forms of motor neuron disease. Goddeau RP, Jr., ed. UpToDate. Waltham, MA: UpToDate Inc. www.uptodate.com. Accessed March 5, 2025.

[3] Elman L, McCluskey L. Clinical features of amyotrophic lateral sclerosis and other forms of motor neuron disease. Goddeau RP, Jr., ed. UpToDate. Waltham, MA: UpToDate Inc. www.uptodate.com. Accessed March 5, 2025.

[4] Vucic S, Ferguson TA, et al. Gold Coast diagnostic criteria: Implications for ALS diagnosis and clinical trial enrollment. Muscle Nerve. 2021 Nov;64(5):532-537. Epub 2021 Aug 24. PMID: 34378224.

[5] Brooks BR, Miller RG, Swash M, Munsat TL. El Escorial revisited: revised criteria for the diagnosis of amyotrophic lateral sclerosis. Amyotroph Lateral Scler Other Motor Neuron Disord. 2000;1: 293-299

[6] de Carvalho M, Dengler R, Eisen A, et al. Electrodiagnostic criteria for diagnosis of ALS. Clin Neurophysiol. 2008;119:497-503.

[7] Hannaford A, Pavey N, van den Bos M, et al. Diagnostic utility of Gold Coast criteria in amyotrophic lateral sclerosis. Ann Neurol. 2021;89: 979-986.

[8] The ALS C.A.R.E. Program. Center for Outcomes Research, University of Massachusetts Medical School. Published online at alspathways.com/wp-content/themes/alspathways/ assets/pdf/ALS-Functional-Rating-Scale-Revised-Guide.pdf by Mitsubishi Tanabe Pharma America in 2017. Accessed February 27, 2024.

[9] Miller RG, et al. Practice parameter update: The care of the patient with amyotrophic lateral sclerosis: drug, nutritional, and respiratory therapies (an evidence-based review): Report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology. 2009 Oct 13;73(15):1218-26. Erratum in: Neurology. 2009 Dec 15;73(24):2134. Erratum in: Neurology. 2010 Mar 2;74(9):781. PMID: 19822872. *Reaffirmed in 2020.*

[10] Miller RG, et al. Practice parameter update: The care of the patient with amyotrophic lateral sclerosis: multidisciplinary care, symptom management, and cognitive/behavioral impairment (an evidence-based review): Report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology. 2009 Oct 13;73(15):1227-33. PMID: 19822873. *Reaffirmed in 2020.*

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

Criteria Change History

Change Date	Changed By	Description of Change	Version
[mm/dd/yyyy]	CAC		
Signature			

Change Date	Changed By	Description of Change	Version
[mm/dd/yyyy]	CAC		
Signature			

Change Date	Changed By	Description of Change	Version
04/18/2025	CAC	Annual review. No changes.	2
Signature William (Bill) Jagiello, DO			

Change Date	Changed By	Description of Change	Version
04/19/2024	CAC	Criteria implementation.	1
Signature William (Bill) Jagiello, DO			

CAC = Medicaid Clinical Advisory Committee