STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Amondys 45 (casimersen)
PAM–044

Iowa Medicaid Program:	Prior Authorization	**Effective Date:**	10/01/2021
Revision Number:	3	**Last Rev Date:**	10/20/2023
Reviewed By:	Medicaid Medical Director	**Next Rev Date:**	10/18/2024
Approved By:	Medicaid Clinical Advisory Committee	**Approved Date:**	04/15/2022

Overview

Medication:[1]	casimersen
Brand Name:	Amondys 45®
Pharmacologic Category:	Antisense oligonucleotide
FDA-Approved Indication(s):	Treatment of Duchenne muscular dystrophy (DMD) in patients with a confirmed mutation of the DMD gene that is amenable to exon 45 skipping. ➢ Accelerated Approval: This indication is approved under accelerated approval based on an increase in dystrophin production in skeletal muscle observed in patients treated with Amondys 45®. Continued approval for this indication may be contingent upon verification of a clinical benefit in confirmatory trials.
How Supplied:	Single-dose vial: 100 mg/2 mL (50 mg/mL)
Dosage and Administration:	Intravenous infusion: 30 mg/kg once weekly
Benefit Category:	Medical

Descriptive Narrative

Duchenne muscular dystrophy (DMD) is a type of dystrophinopathy which occurs as a result of mutations (primarily deletions) in the dystrophin gene. Dystrophin is a protein that is present in skeletal and heart muscles allowing the muscles to function properly. The principal symptom of DMD is weakness, as muscle fiber degeneration is the primary pathologic process.

The dystrophinopathies are inherited as X-linked recessive traits and have varying clinical characteristics, with DMD being associated with the most severe clinical symptoms. In DMD, dystrophin is either absent or found in very small amounts. The majority of mutations of the dystrophin gene are deletions of one or more exons, which are found in approximately 60 to 65 percent of patients with DMD.[2]

Exon skipping is a form of RNA splicing used to cause cells to "skip" over faulty or misaligned sections of genetic code resulting in a truncated, but still functional protein, despite the genetic mutation. Amondys 45® is an antisense oligonucleotide indicated for the treatment of patients who have a confirmed mutation of the DMD gene that is amenable to exon 45 skipping. This type of mutation is present in an estimated 8 percent of patients with DMD.[3]

Guidelines

Guidelines for treatment of Duchenne muscular dystrophy (DMD) were last published in April 2018, and while they do mention the implications of emerging genetic and molecular therapies for DMD, exon-skipping therapies had not yet been FDA-approved and so are not a part of the official guidance.[4,5,6]

Criteria

Prior authorization is required.

Amondys 45® may be considered medically necessary when **ALL** of the following are met:

1. Diagnosis of Duchenne muscular dystrophy (DMD), with a mutation in the *DMD* gene amenable to exon 45 skipping (confirmed by genetic testing); **AND**
2. Member is male and is between 7 and 13 years of age at therapy initiation; **AND**
3. Will not be used concomitantly with other exon-skipping therapies for DMD or with gene therapy treatment for DMD (e.g., Elevidys®); **AND**
4. Member is ambulatory (able to walk with or without an assistive device, not wheelchair dependent) and is able to complete assessment of at least **TWO** of the following:
    a. Time-to-stand from supine; **OR**
    b. 6-minute walk test; **OR**
    c. Time to run/walk 10 meters; **OR**
    d. Time to climb 4 stairs; **AND**
5. Prescribed concurrently with a corticosteroid, unless clinically significant adverse effects are experienced or therapy is contraindicated; **AND**
6. Prescribed by, or in consultation with, a neurologist with expertise in the management of DMD; **AND**
7. The regimen prescribed is within the FDA-approved labeling: 30 mg/kg administered once weekly as an intravenous infusion.

Amondys 45® may be 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 remains ambulatory (with or without an assistive device, not wheelchair dependent); **AND**
3. Prescribed concurrently with a corticosteroid, unless clinically significant adverse effects are experienced or therapy is contraindicated; **AND**
4. Will not be used concomitantly with other exon-skipping therapies for Duchenne muscular dystrophy (DMD) or with gene therapy treatment for DMD (e.g., Elevidys®); **AND**
5. Prescribed by, or in consultation with, a neurologist with expertise in the management of DMD; **AND**
6. The regimen prescribed is within the FDA-approved labeling: 30 mg/kg administered once weekly as an intravenous infusion.

Approval Duration and Quantity Limits

	Approval Duration	Quantity Limits
Initial and Continuation	6 months	30 mg/kg once weekly

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
J1426	Injection, casimersen, 10 mg

ICD-10	Description
G71.01	Duchenne or Becker muscular dystrophy

NDC	Labeler	Dosage	Pkg Size	Pkg Qty	Units/Pkg
60923-0227-02	Sarepta Therapeutics, Inc. (60923)	10 mg	1	EA	10

Compliance

1. Should conflict exist between this 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] Amondys 45® prescribing information (03/2023). Sarepta Therapeutics, Inc.: Cambridge, MA. Available online at: www.amondys45.com. Accessed October 3, 2023.

[2] Darras BT. Duchenne and Becker muscular dystrophy: Genetics and pathogenesis. Dashe JF, ed. UpToDate. Waltham, MA: UpToDate Inc. www.uptodate.com. Accessed October 3, 2023.

[3] Amondys 45: Clinical Pharmacology and Biopharmaceutics Review. Center for Drug Evaluation and Research (CDER). NDA 213026. Available online at www.accessdata.fda.gov. Accessed February 11, 2022.

[4] Birnkrant, David J et al. "Diagnosis and management of Duchenne muscular dystrophy, part 1: Diagnosis, and neuromuscular, rehabilitation, endocrine, and gastrointestinal and nutritional management." The Lancet. Neurology vol. 17,3 (2018): 251-267.

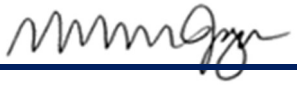
[5] Birnkrant, David J et al. "Diagnosis and management of Duchenne muscular dystrophy, part 2: Respiratory, cardiac, bone health, and orthopaedic management." The Lancet. Neurology vol. 17,4 (2018): 347-361.

[6] Birnkrant, David J et al. "Diagnosis and management of Duchenne muscular dystrophy, part 3: Primary care, emergency management, psychosocial care, and transitions of care across the lifespan." The Lancet. Neurology vol. 17,5 (2018): 445-455.

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
10/20/2023	CAC	Policy review. Edited criteria (added bold portion): "Will not be used concomitantly with other exon-skipping therapies for DMD **or with gene therapy treatment for DMD (e.g., Elevidys®)**." Added same language into continuation criteria.	3
Signature William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
04/21/2023	CAC	Annual review. Added dosing regimen into criteria. Updated references.	2
Signature William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
04/15/2022	CAC	Criteria implementation.	1
Signature William (Bill) Jagiello, DO			

CAC = Medicaid Clinical Advisory Committee