PROVIDER POLICIES & PROCEDURES

LUXTURNA® (VORETIGENE NEPARVOVEC-RZYL)

The primary purpose of this document is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP) with the information needed to support a medical necessity determination for Luxturna. By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

Luxturna is an adeno-associated virus vector-based gene therapy indicated for the treatment of children and adults with confirmed biallelic RPE65 mutation-associated retinal dystrophy, an inherited form of vision loss that may result in blindness. Individuals must have viable retinal cells as determined by the treating physician.

Hereditary retinal dystrophies are associated with progressive visual dysfunction and are caused by genetic mutations. Biallelic mutation carriers have a mutation in both copies of a particular gene (a paternal and a maternal mutation). The RPE65 gene provides instructions for making an enzyme that is essential for normal vision. Mutations in the RPE65 gene lead to reduced or absent levels of RPE65 activity, blocking the visual cycle and resulting in impaired vision. Individuals with biallelic RPE65 mutation-associated retinal dystrophy experience deterioration of vision over time. This loss of vision, often during childhood or adolescence, ultimately leads to complete blindness.

Luxturna delivers a normal copy of the RPE65 gene directly to retinal cells. These retinal cells then produce the normal protein that converts light to an electrical signal in the retina to restore the individual's vision loss. Luxturna uses a naturally occurring adeno-associated virus, which has been modified using recombinant DNA techniques, as a vehicle to deliver the normal human RPE65 gene to the retinal cells to restore vision.

CLINICAL GUIDELINE

Coverage decisions for the use of Luxturna will be made in accordance with the DSS definition of Medical Necessity. The following criteria are guidelines *only*. Coverage decisions are based on an assessment of the individual and their unique clinical needs. If the guidelines conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail. The guidelines are as follows:

I. Luxturna will be considered medically necessary based on the FDA approved indication of confirmed biallelic RPE65 mutation-associated retinal dystrophy when ALL of the following criteria are met:
   A. The individual has a diagnosis, confirmed by genetic testing, of biallelic RPE65 mutation-associated retinal dystrophy; **AND**
   B. Luxturna is prescribed by and will be administered by a retinal specialist; **AND**
   C. The individual has viable retinal cells in the intended eye(s) to be treated as determined by the treating physician; **AND**

D. The individual is ≥ 12 months of age (Safety and efficacy has not been established in individuals under 12 months of age); **AND**
E. The individual is < 65 years of age (Safety and efficacy has not been established in individuals 65 years of age and older); **AND**
F. The individual has not previously received RPE65 gene therapy in the intended eye(s); **AND**
G. The provider will follow all FDA recommendations for dosage, preparation, administration, monitoring and patient education.

II. Luxturna is considered investigational and therefore not medically necessary for all other indications. If an individual requesting treatment with Luxturna does not meet these criteria, an assessment of the individual's unique clinical needs will be conducted.

NOTE: EPSDT Special Provision
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

PROCEDURE
Prior authorization of Luxturna is required. Coverage determinations will be based upon a review of requested and/or submitted case-specific information.

The following information is needed to review requests for Luxturna:
1. Fully completed State of Connecticut, Department of Social Services HUSKY Health Program Luxturna Prior Authorization Request form (to include physician's order and signature);
2. Genetic testing results confirming biallelic RPE65 mutation;
3. Clinical information supporting the medical necessity of the treatment as outlined above; and
4. Other information as requested.

Requesting Authorization
Requests for the prior authorization of Luxturna must be submitted by the ordering physician and faxed to the number listed on the request form. Questions regarding this form should be directed to the HUSKY Health Program Utilization Management Department at 1.800.440.5071 (select option for medical authorizations).

Initial Authorization
If approved, authorization will be given for 1 dose per eye, per lifetime.

Reauthorization
The efficacy of repeat administration with Luxturna in the same eye has not been established. Repeat administration is currently considered investigational and therefore not medically necessary. Requests for reauthorization may be submitted and will be reviewed on a case-by-case basis if supported by published, peer-reviewed literature.

EFFECTIVE DATE
This Policy for the prior authorization of Luxturna for individuals covered under the HUSKY Health Program is effective April 1, 2018.

LIMITATIONS
N/A

CODES:

Code	Definition
J3398	Injection, voretigene neparvovec-rzyl, 1 billion vector genomes

DEFINITIONS

1. **HUSKY A**: Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
2. **HUSKY B**: Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children's Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
3. **HUSKY C**: Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.
4. **HUSKY D**: Connecticut residents who are ages 19-64 without dependent children and who: (1) do not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).
5. **HUSKY Health Program**: The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.
6. **HUSKY Limited Benefit Program or HUSKY, LBP**: Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.
7. **Medically Necessary or Medical Necessity**: (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B)recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.
8. **Prior Authorization**: A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested

service is medically necessary.

ADDITIONAL RESOURCES AND REFERENCES:

1. Centers for Medicare & Medicaid Services Medicare Coverage Database. (2023, April 20). Local Coverage Determination (LCD) Voretigene Neparvovec-Rzyl (Luxturna®). CMS.gov Centers for Medicare & Medicaid Services. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=37863&ver=25&=. Accessed on December 6, 2023
2. Luxturna [package insert].Philadelphia, PA: Spark Therapeutics, Inc.; Revised May 2022
3. Maguire AM, Russell S, Chung DC, Yu ZF, Tillman A, Drack AV, Simonelli F, Leroy BP, Reape KZ, High KA, Bennett J. Durability of Voretigene Neparvovec for Biallelic RPE65-Mediated Inherited Retinal Disease: Phase 3 Results at 3 and 4 Years. Ophthalmology. 2021 Oct;128(10):1460-1468
4. Russell S, Bennett J, Wellman JA, et al. Efficacy and safety of voretigene neparvovec (AAV2-hRPE65v2) in patients with RPE65-mediated inherited retinal dystrophy: a randomised, controlled, open-label, phase 3 trial. Lancet. 2017;390(10097):849-860.
5. Food and Drug Administration (FDA) News Release: FDA approves novel gene therapy to treat patients with a rare form of inherited vision loss. December 19, 2017. https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm589467.htm. Accessed on December 27, 2017.

PUBLICATION HISTORY

Status	Date	Action Taken
Original publication	March 13, 2018	Approved by CHNCT Medical Policy Review Committee on January 24, 2018. Approved by DSS on March 13, 2018. Approved by CHNCT Clinical Quality Subcommittee on March 19, 2018.
Update	February 2019	New HCPCS code specific to voretigene neparvovec-rzyl, J3398, added to code list. Codes J3590 and C9399 removed from list. Code J3398 is reimbursed under OPPS. Reviewed and approved at the February 27, 2019 Medical Reviewer Meeting. Change approved by the CHNCT Clinical Quality Subcommittee on March 18, 2019. Approved by DSS on March 27, 2019.

Update	April 2020	Update to Clinical Guideline section: • Removed specific requirements for dosage, administration, monitoring and patient education. Replaced with *Provider will follow all FDA recommendations for dosage, preparation, administration, monitoring and patient education* • Added the following criteria: *The individual has not previously received this treatment in the same eye* Changes approved at the February 12, 2020 Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 16, 2020. Approved by DSS on April 16, 2020.
Reviewed	March 2021	Reviewed without changes at the January 13, 2021 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 15, 2021. Approved by DSS on March 22, 2021.
Reviewed	March 2022	Reviewed and approved without changes at the February 8, 2022 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 21, 2022. Approved by DSS on March 24, 2022.
Reviewed	March 2023	Reviewed and approved without changes at the February 8, 2023 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 20, 2023. Approved by DSS on March 27, 2023.

Update	December 2023	Update to Clinical Guideline Section: • Criteria requiring that Luxturna is prescribed by and will be administered by a retinal specialist • Clarification that the individual has viable retinal cells “in the intended eye(s) to be treated” • Clarification from “this treatment” to “RPE65 gene therapy” • Consolidated the language in section II Clarified verbiage regarding genetic testing results “confirming biallelic RPE65 mutation” Added “per lifetime” to Initial Authorization Section Added verbiage to Reauthorization Section : • The efficacy of repeat administration with Luxturna in the same eye has not been established. Repeat administration is current considered investigational and therefore not medically necessary. Requests for reauthorization may be submitted and will be reviewed on a case-by-case basis if supported by published, peer-reviewed literature. Updated References Approved at the December 13, 2023 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on December 18, 2023. Approved by DSS on January 03, 2024.
Reviewed	November 2024	Reviewed and approved without changes at the November 13, 2024 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on December 16, 2024. Approved by DSS on December 27, 2024.