EXONDYS 51™ (ETEPLIRSEN)

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 EXONDYS 51™ (eteplirsen). 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.

EXONDYS 51™ (eteplirsen) is a prescription medication used to treat Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 51 skipping.

CLINICAL GUIDELINE

Coverage guidelines for the use of EXONDYS 51™ (eteplirsen) will be made in accordance with the DSS definition of Medical Necessity. The following criteria are guidelines *only*. Coverage guidelines 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:

EXONDYS 51™ (eteplirsen) may be considered medically necessary if the following criteria is met:

A. The individual has a diagnosis of Duchenne muscular dystrophy (DMD) with mutation amenable to exon 51 skipping confirmed by genetic testing (ordering physician MUST provide results of genetic testing); AND
B. Must be prescribed by or in consultation with a physician who specializes in the treatment of Duchenne muscular dystrophy; AND
C. The individual is currently ambulatory (able to walk with or without assistance, not wheelchair dependent) and able to achieve an average distance of at least 180 meters while walking independently over six minutes (ordering physician must attach a baseline 6 – Minute Walk Test [6MWT]); AND
D. The individual is currently stable on an oral corticosteroid regimen for at least 6 months; AND
E. The physician must follow the FDA recommend dose of 30 mg/kg once per week as a 35 to 60 minute intravenous infusion.

Investigational and Not Medically Necessary

The use of EXONDYS 51™ (eteplirsen) is considered investigational and not medically necessary for all other indications.

Continuation of EXONDYS 51™ (eteplirsen) may be considered medically necessary at 6 month intervals if the following criteria is met:

A. The individual has demonstrated a response to therapy as evidenced by remaining ambulatory (able to walk with or without assistance, not wheelchair dependent); AND
B. An updated 6MWT has been provided which indicates that the individual is able to achieve a distance of at least 180 meters.

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 EXONDYS 51™ (eteplirsen) 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 EXONDYS 51™ (eteplirsen):
1. Fully completed State of Connecticut, Department of Social Services HUSKY Health Program EXONDYS 51™ (eteplirsen) Prior Authorization Request form (to include physician's order and signature);
2. Clinical information supporting the medical necessity of the treatment as outlined above to include results of genetic testing and results of a baseline 6 – Minute Walk Test (6MWT).
3. Other information as requested.

Requesting Authorization
Requests for the prior authorization of EXONDYS 51™ (eteplirsen) 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
Initial approval of EXONDYS 51™ (eteplirsen) will be for 6 months to be given in accordance with the current EXONDYS 51™ (eteplirsen) FDA label instructions.

Re-authorization
Requests for continuation of EXONDYS 51™ (eteplirsen) will be considered at 6 month intervals if the medical necessity criteria, as outlined above, are met.

EFFECTIVE DATE
This Policy for the prior authorization of EXONDYS 51™ (eteplirsen) for individuals covered under the HUSKY Health Program is effective November 1, 2017.

LIMITATIONS
Not Applicable

CODES:

Code	Definition
C9484	Injection, eteplirsen, 10 mg (code will be deleted 12/31/2017)
J1428	Injection, eteplirsen, 10 mg (code will be effective 1/1/2018)

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:

Anthony K, Feng L, Arechavala-Gomeza V, et al. Exon skipping quantification by quantitative reverse-transcription polymerase chain reaction in Duchenne muscular dystrophy patients treated with the antisense oligomer eteplirsen. Hum Gene Ther Methods. 2012 Oct;23(5):336-45.

Bushby K, Finkel R, Birnkrant DJ, Case LE, Clemens PR, Cripe L, et al. Diagnosis and management of Duchenne muscular dystrophy, part 1: diagnosis, and pharmacological and psychosocial management. Lancet Neurol; 2010 Jan; 9(1):77-93.

Bushby K, Finkel R, Birnkrant DJ, et al. (2010) Diagnosis and management of Duchenne muscular dystrophy, part 2: implementation of multidisciplinary care. Lancet Neurol; 2010 Feb; 9(2):177-189.

Centers for Disease Control and Prevention (CDC). Duchenne/Becker Treatment and Care. Last updated July 19, 2016. http://www.cdc.gov/ncbddd/musculardystrophy/treatments.html. Accessed on November 10, 2017.

Exondys 51 [Product Information]. Cambridge, MA. Sarepta Therapeutics, Inc. Revised September 19, 2016. http://www.accessdata.fda.gov/drugsatfda_docs/label/2016/206488lbl.pdf. Accessed on November 10, 2017.

Food and Drug Administration (FDA) Briefing Document: Peripheral and Central Nervous System Drugs Advisory Committee Meeting. January 22, 2016. http://www.fda.gov/downloads/advisorycommittees/committeesmeetingmaterials/drugs/peripheralandcentralnervoussystemdrugsadvisory committee/ucm481911.pdf. Accessed on November 10, 2017.

Food and Drug Administration (FDA) Center for Drug Evaluation and Research. Summary minutes of the Peripheral and Central Nervous System Drugs Advisory Committee Meeting. April 25, 2016. http://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/Drugs/PeripheralandCentralNervousSystemDrugs AdvisoryCommittee/UCM509870.pdf. Accessed on November 10, 2017.

Genetics Home Reference. DMD gene. Last updated February 2017. http://ghr.nlm.nih.gov/gene/DMD. Accessed on November 10, 2017.

Genetics Home Reference. Duchenne and Becker muscular dystrophy. Last updated November 2016. http://ghr.nlm.nih.gov/condition/duchenne-and-becker-muscular-dystrophy. Accessed on November 10, 2017.

Mendell JR, Rodino-Klapac LR, Sahenk Z, et al. Eteplirsen for the treatment of Duchenne muscular dystrophy. Ann Neurol. 2013 Nov;74(5):637-47.

Muscular Dystrophy Association (MDA). Duchenne Muscular Dystrophy (DMD). 2017. https://www.mda.org/disease/duchenne-muscular-dystrophy. Accessed on November 10, 2017.

Sarepta Therapeutics. An Open-Label, Multi-Center Study to Evaluate the Safety and Tolerability of Eteplirsen in Early Stage Duchenne Muscular Dystrophy. NLM Identifier: NCT02420379. Last Updated

on October 3, 2017. https://clinicaltrials.gov/ct2/show/NCT02420379?term=02420379&rank=1. Accessed on November 10, 2017.

Sarepta Therapeutics. An Open-Label, Multi-Center Study to Evaluate the Safety and Tolerability of Eteplirsen in Members With Advanced Stage Duchenne Muscular Dystrophy. NLM Identifier: NCT02286947. Last Updated on October 4, 2017. https://clinicaltrials.gov/ct2/show/NCT02286947?term=NCT02286947&rank=1. Accessed on November 10, 2017.

Sarepta Therapeutics. Confirmatory Study of Eteplirsen in DMD Members (PROMOVI). NLM Identifier: NCT02255552. Last Updated on October 3, 2017. https://www.clinicaltrials.gov/ct2/show/nct02255552?term=eteplirsen&rank=4. Accessed on November 10, 2017.

PUBLICATION HISTORY

Status	Date	Action Taken
Original publication	November 2017	Approved by DSS on November 14, 2017. Approved by Clinical Quality Subcommittee on December 18, 2017.
Reviewed	October 2018	Reviewed and approved without changes by CHNCT Medical Policy Committee on October 10, 2018. Approved by CHNCT Clinical Quality Subcommittee on December 17, 2018. Approved by DSS on January 28, 2019.