

Clinical Policy: Eplontersen (Wainua)

Reference Number: CP.PHAR.633

Effective Date: 12.21.23

Last Review Date: 08.24

Line of Business: Commercial, HIM, Medicaid

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Eplontersen (Wainua[™]) is a transthyretin (TTR)-directed antisense oligonucleotide.

FDA Approved Indication

Wainua is indicated for the treatment of polyneuropathy of hereditary TTR-mediated amyloidosis in adults.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that Wainua is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Hereditary Transthyretin-Mediated Amyloidosis (must meet all):

1. Diagnosis of hereditary TTR-mediated amyloidosis with polyneuropathy;
2. Documentation confirms presence of a TTR mutation;
3. Biopsy is positive for amyloid deposits or medical justification is provided as to why treatment should be initiated despite a negative biopsy or no biopsy;
4. Prescribed by or in consultation with a neurologist;
5. Age \geq 18 years;
6. Member has not had a prior liver transplant;
7. Member has not received prior treatment with Onpattro[®] or Amvuttra[™];
8. Wainua is not prescribed concurrently with Onpattro or Amvuttra;
9. Dose does not exceed 45 mg once monthly.

Approval duration:

Medicaid/HIM – 6 months

Commercial – 6 months or to the member's renewal date, whichever is longer

B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business:

- CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
- b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
- 2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Hereditary Transthyretin-Mediated Amyloidosis (must meet all):

- 1. Member meets one of the following (a or b):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
 - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
- 2. Member is responding positively to therapy as evidenced by, including but not limited to, improvement in any of the following parameters: measures of polyneuropathy (e.g., motor strength, sensation, and reflexes), quality of life, motor function, walking ability, and nutritional status (e.g., as evaluated by modified mass index);
- 3. Member has not had a prior liver transplant;
- 4. Wainua is not prescribed concurrently with Onpattro or Amvuttra;
- 5. If request is for a dose increase, new dose does not exceed 45 mg once monthly.

Approval duration:

Medicaid/HIM – 12 months

Commercial – 6 months or to the member’s renewal date, whichever is longer

B. Other diagnoses/indications (must meet 1 or 2):

- 1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
- 2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND

criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

TTR: transthyretin

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

None reported

Appendix D: General Information

- To confirm amyloidosis, the demonstration of amyloid deposits via tissue biopsy is essential. Deposition of amyloid in the tissue can be demonstrated by Congo red staining of biopsy specimens. With Congo red staining, amyloid deposits show a characteristic green birefringence under polarized light; however, negative biopsy results should not be interpreted as excluding the disease.
- DNA sequencing is usually required for genetic confirmation. Current techniques for performing sequence analysis of TTR, the only gene known to be associated with TTR amyloidosis, detect > 99% of disease-causing mutations.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Hereditary TTR-mediated amyloidosis with polyneuropathy	45 mg SC once monthly	45 mg/month

VI. Product Availability

Single-dose autoinjector: 45 mg/0.8 mL

VII. References

1. Wainua Prescriber Information. Wilmington, DE: AstraZeneca Pharmaceuticals; December 2023. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/217388s0001bl.pdf. Accessed May 09, 2024.

2. ClinicalTrials.gov. NEURO-TTRansform: A study to evaluate the efficacy and safety of eplontersen (Formerly Known as ION-682884, IONIS-TTR-LRx and AKCEA-TTR-LRx) in participants with hereditary transthyretin-mediated amyloid polyneuropathy. Available at: <https://clinicaltrials.gov/ct2/show/NCT04136184>. Accessed May 28, 2024.
3. Ando Y, Coelho T, Berk JL, et al. Guideline of transthyretin-related hereditary amyloidosis for clinicians. Orphanet J Rare Dis. 2013 Feb 20;8:31.
4. Magrinelli F, Fabrizi GM, Santoro L, et al. Pharmacological treatment for familial amyloid polyneuropathy. Cochrane Database Syst Rev. 2020 Apr 20;4(4):CD012395.
5. Luigetti M, Romano A, Di Paolantonio A, et al. Diagnosis and treatment of hereditary transthyretin amyloidosis (hATTR) polyneuropathy: current perspectives on improving patient care. Therapeutics and Clinical Risk Management. 2020;16:109–23.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
C9399	Unclassified drugs or biologicals
J3490	Unclassified drugs

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created pre-emptively	05.01.23	08.23
RT4: drug is now FDA approved- criteria updated per FDA labeling; added HCPCS codes [C9399] and [J3490].	01.09.24	
2Q 2024 annual review: no significant changes; references reviewed and updated.	02.12.24	05.24
3Q 2024 annual review: removed Tegsedi [®] from criteria as agent will be discontinued September 2024 per Sobi manufacturer; references reviewed and updated.	05.09.24	08.24

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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