



## **VYONDYS 53™ (GOLODIRSEN)**

**Policy Number:** CSLA2020D0086A

**Effective Date:** TBD

[Instructions for Use](#) ⓘ

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### **Related Community Plan Policy(ies)**

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### **Commercial Policy**

- [Vyondys 53 \(golodirsen\)](#)

## **APPLICATION**

**This Medical Benefit Drug Policy only applies to the state of Louisiana.**

## **COVERAGE RATIONALE**

**Vyondys 53 (golodirsen) may be covered for the treatment of Duchenne muscular dystrophy (DMD) in patients who meet all of the following criteria:**

- **For initial therapy, all of the following:**
  - **Diagnosis of Duchenne muscular dystrophy by, or in consultation with, a neurologist with expertise in the diagnosis of DMD; and**
  - **Submission of medical records (e.g., chart notes, laboratory values) confirming the mutation of the DMD gene is amenable to exon 53 skipping; and**
  - **One of the following:**
    - **Submission of medical records (e.g., chart notes, laboratory values) confirming that the patient has a 6-Minute Walk Time (6MWT) ≥ 300 meters while walking independently (e.g., without side-by-side assist, cane, walker, wheelchair, etc.) prior to beginning Vyondys 53 therapy; or**
    - **Both of the following:**
      - **Submission of medical records (e.g., chart notes) confirming that the patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.); and**
      - **One of the following:**
        - **Patient has achieved a score of greater than 17 on the North Star Ambulatory Assessment (NSAA); or**
        - **Patient has achieved a time to rise from the floor (Gower’s test) of less than 7 seconds; and**
  - **Vyondys 53 is prescribed by, or in consultation with, a neurologist with expertise in the treatment of DMD; and**
  - **Vyondys 53 dosing for DMD is in accordance with the United States Food and Drug Administration approved labeling: maximum dosing of 30 mg/kg infused once weekly; and**
  - **Vyondys 53 is not used concomitantly with other exon skipping therapies for DMD; and**
  - **Initial authorization will be for no more than 6 months.**

- **For continuation therapy, all of the following:**
  - **Vyondys 53 is prescribed by, or in consultation with, a neurologist with expertise in the treatment of DMD; and**
  - **Submission of medical records (e.g., chart notes) confirming that the patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.); and**
  - **Serial monitoring of renal function (e.g. serum creatinine, proteinuria, serum cystatin C, 24-hour urine collection, etc.) has failed to identify evidence of renal toxicity with Vyondys 53; and**
  - **Vyondys 53 dosing for DMD is in accordance with the United States Food and Drug Administration approved labeling: maximum dosing of 30 mg/kg infused once weekly; and**
  - **Vyondys 53 is not used concomitantly with other exon skipping therapies for DMD; and**
  - **Reauthorization will be for no more than 12 months.**

**Vyondys 53 will not be covered for other forms of muscular dystrophy.**

## **APPLICABLE CODES**

**The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply.**

<b>HCPCS Code</b>	<b>Description</b>
<b><u>C9399</u></b>	<b><u>Unclassified drugs or biologicals</u></b>
<b><u>J3490</u></b>	<b><u>Unclassified drugs</u></b>
<b><u>J3590</u></b>	<b><u>Unclassified biologics</u></b>

<b>ICD-10 Diagnosis Code</b>	<b>Description</b>
<b><u>G71.01</u></b>	<b><u>Duchenne or Becker muscular dystrophy</u></b>

## **BACKGROUND**

**Duchenne muscular dystrophy (DMD) is an X-linked disease that affects 1 in 3,600 – 6,000 live male births. DMD occurs as a result of mutations (mainly deletions) in the dystrophin gene. These mutations lead to an absence or a defect of the protein, dystrophin, resulting in progressive muscle degeneration, leading to loss of ambulation and additional respiratory, orthopedic, and cardiac complications. If left untreated, mean age of death is approximately 19 years of age.<sup>2-4</sup>**

**Golodirsen is an antisense oligonucleotide of the phosphorodiamidate morpholino oligomer (PMO) subclass. PMOs are synthetic molecules in which the five-membered ribofuranosyl rings found in natural DNA and RNA are replaced by a six-membered morpholino ring. Each morpholino ring is linked through an uncharged phosphorodiamidate moiety rather than the negatively charged phosphate linkage that is present in natural DNA and RNA. Each phosphorodiamidate morpholino subunit contains one of the heterocyclic bases found in DNA (adenine, cytosine, guanine, or thymine).<sup>1</sup>**

**Golodirsen is designed to bind to exon 53 of dystrophin pre-mRNA, resulting in exclusion of this exon during mRNA processing in patients with genetic mutations that are amenable to exon 53 skipping. Approximately 8% of DMD patients have out-of frame deletion mutations amenable to exon 53 skipping. Exon skipping is intended to allow for production of an internally truncated dystrophin protein.<sup>1</sup>**

**Eteplirsen (Exondys 51) is the first PMO approved by the US Food and Drug Administration for treatment of DMD patients with confirmed genetic mutations amenable to exon 51 skipping. Approximately 13% of DMD patients have out-of frame deletion mutations amenable to exon 51 skipping. This indication was approved under accelerated approval based on an increase in dystrophin in skeletal muscle observed in**

some patients treated with eteplirsen A clinical benefit of eteplirsen has not been established. Continued approval for this indication may be contingent upon verification of a clinical benefit in confirmatory trials.<sup>5</sup>

## **CLINICAL EVIDENCE**

Vyondys 53 is indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 53 skipping.<sup>1</sup>

The SKIP-NMD trial of golodirsen is a US-based, blinded, placebo-controlled, dose-escalation two-part Phase I/II RCT of male patients aged six to 15 years with a DMD diagnosis and DMD gene amenable to exon 53 skipping. Patients age 6 to 15 years with stable cardiac and pulmonary function, and on a stable dose of corticosteroids for at least six months were included. Additional inclusion criteria included a baseline six-minute walk test (6MWT) of greater than 250m, a North Star Ambulatory Assessment (NSAA) score of greater than 17 or a rise time of less than 7 seconds. In part one, 12 patients were randomized to receive once-weekly intravenous infusions at escalating doses of 4, 10, 20, 30 mg/kg of golodirsen or matching placebo for 12 weeks. Part two consists of an open-label period of all patients from part one and 13 newly recruited patients who are receiving once-weekly infusions of 30 mg/kg of golodirsen for up to 168 weeks.

Part one of the SKIP-NMD trial assessed safety and tolerability. In part two, the primary endpoints are change from baseline in 6MWT at 144 weeks and change in dystrophin protein levels at 48 weeks. Secondary endpoints include drug pharmacokinetics, change from baseline in FVC percent predicted, and change from baseline in dystrophin intensity at 144 weeks.

At the time of pre-planned interim analysis, data from baseline and Week 48 muscle biopsies, exon 53 skipping, and dystrophin localization were available for 25 patients on golodirsen. The study is ongoing, and results for the primary efficacy endpoint of 6MWT at Week 144 are not yet available. Mean baseline of dystrophin in the trial was reported to be 0.095% of normal. At 48 weeks, the mean level of dystrophin had increased to 1.019% of normal resulting in an absolute increase of 0.918% of normal (p<0.001). A clinically meaningful change in level of dystrophin has not yet been established in humans. As such, the clinical significance of these results is not clear. Among individual patients, dystrophin levels at Week 48 ranged from 0.09% to 4.30%.<sup>6-8</sup>

ESSENCE is an ongoing 96-week, Phase 3, double-blind, placebo controlled, randomized clinical trial that will evaluate the efficacy of golodirsen and casimersen in DMD patients with out-of-frame deletion mutations amenable to skipping exon 53 and exon 45, respectively. The study will enroll 222 boys from 7 to 13 years of age with genotypically confirmed DMD and 6MWT  $\geq$  300 m and  $\leq$  450 m. The primary endpoint is the change from baseline to Week 96 in 6MWT

Vyondys 53 has not been studied in DMD that is not amenable to exon 53 skipping, nor in other forms of muscular dystrophy (e.g, Becker muscular dystrophy).<sup>1</sup>

## **U.S. FOOD AND DRUG ADMINISTRATION (FDA)**

Vyondys 53 is indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 53 skipping. This indication is approved under accelerated approval based on an increase in dystrophin in skeletal muscle observed in some patients treated with Vyondys 53. A clinical benefit of Vyondys 53 has not been established. Continued approval for this indication may be contingent upon verification of a clinical benefit in confirmatory trials.<sup>1</sup>

## **CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)**

Medicare does not have a National Coverage Determination (NCD) for Vyondys 53<sup>TM</sup> (golodirsen) Local Coverage Determinations (LCDs) do not exist at this time.

In general, Medicare covers outpatient (Part B) drugs that are furnished "incident to" a physician's service provided that the drugs are not usually self-administered by the patients who take them. Refer to the [Medicare Benefit Policy Manual, Chapter 15, §50 - Drugs and Biologicals](#). (Accessed December 12, 2019)

## REFERENCES

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## POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
TBD	• <u>New policy.</u>

## INSTRUCTIONS FOR USE

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The UnitedHealthcare Medical Benefit Drug Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.