Clinical Policy: Tofersen (~~BIIB067~~Qalsody)

Reference Number: LA.PHAR.591
Effective Date: ~~FDA Approval Date~~
Last Review Date: ~~05.01~~07.24.23
Line of Business: Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Please note: This policy is for medical benefit

Description

Tofersen (~~BIIB067~~®/™Qalsody™) is an antisense oligonucleotide.

FDA Approved Indication(s) ~~[Pending]~~

~~BIIB067~~Qalsody is ~~proposed~~indicated for the treatment of ~~superoxide dismutase 1 (*SOD1*)~~ amyotrophic lateral sclerosis (ALS) in adults who have a mutation in the superoxide dismutase 1 (*SOD1*) gene.

This indication is approved under accelerated approval based on reduction in plasma neurofilament light chain observed in patients treated with Qalsody. Continued approval for this indication may be contingent upon verification of clinical benefit in confirmatory trial(s).

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 Louisiana Healthcare Connections® that ~~BIIB067~~Qalsody is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria~~*~~

~~**Criteria will mirror the clinical information from the prescribing information once FDA approved*~~

A. Amyotrophic Lateral Sclerosis (must meet all)**:**

1. Diagnosis of ALS with both of the following (a and b~~):*~~):
   a. Muscle weakness attributed to ALS;
   b. Documentation of *SOD1* mutation;
2. Prescribed by or in consultation with a neurologist;
3. Age ≥ 18 years~~;*~~;
4. Percent predicted slowed vital capacity (SVC) ≥ ~~45%;*~~50%;
5. Prescribed concurrently with riluzole (at up to maximally indicated doses), unless contraindicated or clinically significant adverse effects are experienced~~;*~~;
6. Member does not have presence of tracheostomy or permanent ventilation;
~~6.~~7. Dose does not exceed ~~the FDA-approved maximum~~100 mg (1 vial) on days 1, 15, and 29, followed by maintenance dose~~.*~~ of 100 mg (1 vial) every 28 days.

Approval duration: 6 months

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 LA.PMN.255
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: LA.PMN.53 for Medicaid.

II. Continued Therapy*

~~**Criteria will mirror the clinical information from the prescribing information once FDA approved*~~

A. Amyotrophic Lateral Sclerosis (must meet all)**:**
a. Currently receiving medication via Louisiana Healthcare Connections benefit or member has previously met initial approval criteria;
1. Member is responding positively to therapy~~;*~~ (e.g., no tracheostomy or permanent ventilation);
2. Prescribed concurrently with riluzole (at up to maximally indicated doses), unless contraindicated or clinically significant adverse effects are experienced~~;*;~~
3. If request is for a dose increase, new dose does not exceed ~~the FDA-approved maximum dose.*~~100 mg (1 vial) every 28 days.

Approval duration: 12 months

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 LA.PMN.255
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: LA.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 – LA.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ALS: amyotrophic lateral sclerosis
FDA: Food and Drug Administration
LMN: lower motor neuron
SOD1: superoxide dismutase 1
SVC: slowed vital capacity
UMN: upper motor neuron

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings ~~[Pending]~~
~~• Contraindication(s): pending~~
~~• Boxed warning(s): pending~~
None reported

Appendix D: General Information
- Revised El Escorial diagnostic criteria for ALS requires the presence of:
  1. Signs of lower motor neuron (LMN) degeneration by clinical, electrophysiological or neuropathologic examination~~,~~;
  2. Signs of upper motor neuron (UMN) degeneration by clinical examination, and
  3. Progressive spread of signs within a region or to other regions, together with the absence of:
     a. Electrophysiological evidence of other disease processes that might explain the signs of LMN and/or UMN degenerations; and
     b. Neuroimaging evidence of other disease processes that might explain the observed clinical and electrophysiological signs.
- Gold Coast consensus diagnostic criteria for ALS requires the presence of:
  1. Progressive motor impairment documented by history or repeated clinical assessment, preceded by normal motor function~~,~~; and
  2. Presence of upper and lower motor neuron dysfunction in at least 1 body region, (with upper and lower motor neuron dysfunction noted in the same body region if only one body region is involved) or lower motor neuron dysfunction in at least 2 body regions, and
  3. Investigations excluding other disease processes.

Appendix E: Riluzole Co-administration
Guidelines support the co-administration of riluzole in ALS:
- The 2009 American Academy of Neurology ALS guideline for the care of the patient with ALS (reaffirmed January 2020) recommends that riluzole should be offered to slow disease progression (Level A).
- The 2020 Canadian best practice recommendations for the management of ALS state the following: riluzole has demonstrated efficacy in improving survival in ALS (level A), there is evidence that riluzole prolongs survival by a median duration of 3 months (level A), and riluzole should be started soon after the diagnosis of ALS (expert consensus).
- Additionally, approximately 62% of patients in the phase 3 VALOR trial were receiving concomitant riluzole.

V. Dosage and Administration ~~[Pending]~~

Indication	Dosing Regimen	Maximum Dose
SOD1 ALS*	~~Pending~~Initiate recommended dose of 100 mg with 3 loading doses administered intrathecally at 14-day intervals. Maintenance dose of 100 mg should be administered intrathecally once every 28 days thereafter.	~~Pending~~ 100 mg/dose/day

VI. Product Availability ~~[Pending]~~

~~Pending~~
Single-dose vial for injection: 100 mg/mL

VII. References

~~1. ClinicalTrials.gov. an efficacy, safety, tolerability, pharmacokinetics and pharmacodynamics study of BIIB067 in adults with inherited ALS (VALOR (Part C)). Last updated July 19, 2022. Available at: https://clinicaltrials.gov/ct2/show/NCT02623699. Accessed August 9, 2022.~~

1. Qalsody Prescribing Information. Cambridge, MA: Biogen; April 2023. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/215887s000lbl.pdf. Accessed May 1, 2023.
2. Brooks BR, Miller RG, Swash M, et al. El Escorial revisited: revised criteria for the diagnosis of amyotrophic lateral sclerosis. Amyotroph Lateral Scler Other Motor Neuron Disord. 2000 Dec;1(5):293-9.
3. Shefner JM, Al-Chalabi A, Baker MR, et al. A proposal for new diagnostic criteria for ALS. Clin Neurophysiol. 2020;131(8):1975-1978.
4. Miller RG, Jackson CE, Kasarskis EJ, et al. Practice parameter update: the care of the patient with amyotrophic lateral sclerosis: drug, nutritional, and respiratory therapies (an evidence-based review): report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology. 2009 Oct 13;73(15):1218-26.
5. Shoesmith C, Abrahao A, Benstead T, et al. Canadian best practice recommendations for the management of amyotrophic lateral sclerosis. CMAJ. 2020 Nov;192(46):E1453-E1468.
6. Miller T, Cudkowicz M, Shaw PJ, et al. Phase 1-2 Trial of Antisense Oligonucleotide Tofersen for *SOD1* ALS. N Engl J Med. 2020;383(2):109-119.

Coding Implications ~~[Pending]~~

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
~~Pending~~C9399	~~Pending~~Unclassified drugs or biologicals
J3490	Unclassified drugs

CLINICAL POLICY
Tofersen

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Policy created	05.01.23	
Criteria updated per approved FDA labeling: updated SVC ≥ 50% to reflect SVC eligibility criteria from VALOR part C trial, added no tracheostomy or permanent assisted ventilation for initial approval criteria and positive response continuation criteria, and updated maximum dose criteria; references reviewed and updated.	07.24.23	

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. LHCC 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.

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 LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. 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. LHCC 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 LHCC has no control or right of control. Providers are not agents or employees of LHCC.