Clinical Policy: Patisiran (Onpattro)

Reference Number: PA.CP.PHAR.395
Effective Date: 10.17.18
Last Review Date: 10.17.18

Revision Log

Description
Patisiran (Onpattro™) is a double-stranded small interfering ribonucleic acid, formulated as a lipid complex for delivery to hepatocytes.

FDA Approved Indication(s)
Onpattro is indicated for the treatment of the polyneuropathy of hereditary transthyretin-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 PA Health & Wellness® that Onpattro 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 transthyretin-mediated amyloidosis with polyneuropathy;
2. Documented transthyretin (TTR) mutation (e.g., genetic testing, DNA sequencing);
3. Prescribed by or in consultation with a neurologist;
4. Member has not had a prior liver transplant;
5. Dose does not exceed the following (based on actual body weight):
   a. Weight < 100 kg: 0.3 mg/kg once every 3 weeks;
   b. Weight ≥ 100 kg: 30 mg once every 3 weeks.

Approval duration: 6 months

B. Other diagnoses/indications

1. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): PA.CP.PMN.53.

II. Continued Therapy

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

1. Currently receiving medication via Pennsylvania Health and Wellness benefit or member has previously met all initial approval criteria or the Continuity of Care Policy (PA.LTSS.PHAR.01) applies;
2. Member is responding positively to therapy [e.g., improved measures of polyneuropathy (e.g., motor strength, sensation, and reflexes), improvement in quality of life, motor function, walking ability (e.g., as measured by timed 10-m walk test), and nutritional status (e.g., as evaluated by modified mass index)];
3. If request is for a dose increase, new dose does not exceed the following (based on actual body weight):

a. Weight < 100 kg: 0.3 mg/kg once every 3 weeks;
b. Weight ≥ 100 kg: 30 mg once every 3 weeks.

Approval duration: 12 months

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

1. Currently receiving medication via Pennsylvania Health and Wellness benefit or member has previously met all initial approval criteria or the Continuity of Care Policy (PA.LTSS.PHAR.01) applies.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): PA.CP.PMN.53.

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 policy – PA.CP.PMN.53 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 transthyretin-mediated amyloidosis-associated polyneuropathy	• Adults weighing < 100 kg: 0.3 mg/kg IV every 3 weeks • Adults weighing ≥ 100 kg: 30 mg IV every 3 weeks • Premedicate with a corticosteroid, acetaminophen, and antihistamines to	See dosing regimen

Indication	Dosing Regimen	Maximum Dose
	reduce the risk of infusion-related reactions. • Onpattro should be administered by a healthcare professional.	

VI. Product Availability

Lipid complex injection (single-dose vial): 10 mg/5 mL (2 mg/mL)

VII. References

1. Onpattro Prescribing Information. Cambridge, MA: Alnylam Pharmaceuticals, Inc.; August 2018. Available at: https://www.onpattro.com/. Accessed August 21, 2018.
2. Ando Y, Coelho T, Berk JL, Cruz MW, Ericzon BG, Ikeda S, et al. Guideline of transthyretin-related hereditary amyloidosis for clinicians. Orphanet J Rare Dis. 2013 Feb 20;8:31.
3. Adams D, Gonzalez-Duarte A, O'Riordan WD, Yang CC, Ueda M, Kristen AV, et al. Patisiran, an RNAi Therapeutic, for Hereditary Transthyretin Amyloidosis. N Engl J Med. 2018 Jul 5;379(1):11-21.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	10/18	