Prior Authorization Review Panel

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CHC-MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
Policies submitted without this form will not be considered for review.

Plan: PA Health & Wellness	**Submission Date: 02/01/2020**
Policy Number: PA.CP.PHAR.432	**Effective Date: 01/15//2020** **Revision Date: 01/15/2020**
Policy Name: Tafamidis (Vyndaqel, Vyndamax)	

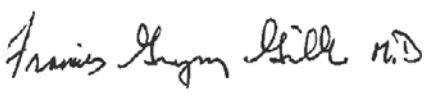
Type of Submission – Check all that apply:

- ✓ **New Policy**
- ☐ **Revised Policy***
- ☐ **Annual Review - No Revisions**
- ☐ **Statewide PDL -** *Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.*

***All revisions to the policy must be highlighted using track changes throughout the document.**

Please provide any changes or clarifying information for the policy below:

New Policy Created

Name of Authorized Individual (Please type or print): **Francis G. Grillo, MD**	**Signature of Authorized Individual:** 

Clinical Policy: Tafamidis (Vyndaqel, Vyndamax)

Reference Number: PA.CP.PHAR.432
Effective Date: 01/2020
Last Review Date: 01/2020

Coding Implications
Revision Log

Description
Tafamidis meglumine (Vyndaqel®) and tafamidis (Vyndamax™) are transthyretin stabilizers.

FDA Approved Indication(s)
Vyndaqel and Vyndamax are indicated for the treatment of the cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) in adults to reduce cardiovascular mortality and cardiovascular-related hospitalization.

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 Vyndaqel and Vyndamax are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Transthyretin Amyloid Cardiomyopathy (must meet all)**:**

1. Diagnosis of cardiomyopathy caused by ATTR;
2. Prescribed by or in consultation with a cardiologist;
3. Age ≥ 18 years;
4. Biopsy is positive for amyloid deposits;
5. One of the following (a or b):
   a. Confirmation of TTR precursor protein (e.g., by immunohistochemistry, scintigraphy, mass spectrometry);
   b. Confirmation of a TTR mutation by genetic testing;
6. Member has not had a liver transplant;
7. Dose does not exceed either of the following (a or b):
   a. Vyndaqel: 80 mg (4 capsules) per day;
   b. Vyndamax: 61 mg (1 capsule) per day.

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. Transthyretin Amyloid Cardiomyopathy (must meet all)**:**
1. Currently receiving medication via PA Health & Wellness benefit and documentation supports positive response to therapy or the Continuity of Care policy (PA.LTSS.PHAR.01) applies;
2. Member is responding positively to therapy, including but not limited to improvement or stabilization in any of the following parameters:
   a. Walking ability;
   b. Nutrition (e.g., body mass index);
   c. Cardiac related hospitalization;
   d. Cardiac procedures or laboratory tests (e.g., Holter monitoring, echocardiography, electrocardiogram, plasma BNP or NT-proBNP, serum troponin);
3. Dose does not exceed either of the following (a or b):
   a. Vyndaqel: 80 mg (4 capsules) per day;
   b. Vyndamax: 61 mg (1 capsule) per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via PA Health & Wellness benefit and documentation supports positive response to therapy 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 policies – PA.CP.PMN.53

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
ATTR-CM: cardiomyopathy of transthyretin-mediated amyloidosis
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings
None reported

V. Dosage and Administration

Drug Name	Dosing Regimen	Maximum Dose
Tafamidis (Vyndaqel)	20 mg (4 capsules) PO QD	80 mg/day
Tafamidis (Vyndamax)	61 mg (1 capsule) PO QD	61 mg/day

VI. Product Availability

Drug Name	Availability
Tafamidis (Vyndaqel)	Capsules: 20 mg
Tafamidis (Vyndamax)	Capsules: 61 mg

VII. References

1. Vyndaqel, Vyndamax Prescribing Information. New York, NY; Pfizer, Inc., May 2019. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/211996s000,212161s000lbl.pdf. Accessed June 10, 2019.
2. Maurer MS, et al. Tafamidis treatment for patients with transthyretin amyloid cardiomyopathy. N Engl J Med. 2018; 379(11): 1007-1016.
3. 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; 8: 31.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	01/2020	