Clinical Policy: Tofersen (Qalsody)

Reference Number: PA.CP.PHAR.591
Effective Date: 08/2023
Last Review Date: 07/2023

Description
Tofersen (Qalsody) is an antisense oligonucleotide.

FDA Approved Indication(s)
Qalsody is indicated for the treatment of 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 PA Health & Wellness® that Qalsody is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

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) ≥ 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;
7. Dose does not exceed 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

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. Amyotrophic Lateral Sclerosis (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;
3. Prescribed concurrently with riluzole (at up to maximally indicated doses), unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for a dose increase, new dose does not exceed 100 mg (1 vial) every 28 days.

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 12 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business 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

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

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

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

Indication	Dosing Regimen	Maximum Dose
SOD1 ALS	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.	100 mg/dose/day

VI. Product Availability

Single-dose vial for injection: 100 mg/mL

VII. References

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
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	07/2023	