



PROVIDER POLICIES & PROCEDURES

GENE-BASED THERAPY FOR DUCHENNE MUSCULAR DYSTROPHY (DMD)

The primary purpose of this document is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP) with the information needed to support a medical necessity determination for gene-based therapy for Duchenne muscular dystrophy (DMD). By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

This policy applies to the following gene-based therapies for DMD: Exondys 51 (eteplirsen), Vyondys 53[®] (golodirsen), Vilteps[®] (viltolarsen), Amondys 45[®] (casimersen) and Elevidys[®] (delandistrogene moxeparvovec-rokl).

Exon-Skipping Gene Therapies:

- Exondys 51 (eteplirsen) is a prescription medication used to treat DMD in patients who have a confirmed mutation of the DMD gene that is amenable to exon 51 skipping.
- Vyondys 53 (golodirsen) and Vilteps[®] (viltolarsen) are prescription medications used to treat DMD in patients who have a confirmed mutation of the DMD gene that is amenable to exon 53 skipping.
- Amondys 45 (casimersen) is a prescription medication used to treat DMD in patients who have a confirmed mutation of the DMD gene that is amenable to exon 45 skipping.

Micro-dystrophin Gene Therapies:

- Elevidys (delandistrogene moxeparvovec-rokl) is a one-time infused adeno-associated virus vector-based gene therapy used to treat DMD in individuals at least 4 years of age who have a confirmed mutation of the DMD gene. It leads to the production of Elevidys micro-dystrophin that contains selected domains of the dystrophin protein present in normal muscle cells.

CLINICAL GUIDELINE

Coverage guidelines for gene-based therapy for DMD will be made in accordance with the DSS definition of Medical Necessity. The following criteria are guidelines only. Coverage guidelines are based on an assessment of the individual and their unique clinical needs. If the guidelines conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail. The guidelines are as follows:

A. Exon-Skipping Gene Therapies (Exondys 51, Vyondys 53, Vilteps[®], Amondys 45)

1. Initial Authorization

An initial 6-month trial of gene-based exon-skipping therapy for DMD may be considered medically necessary when the following criteria are met:

- a. The individual has a diagnosis of DMD and a mutation amenable to exon 51 skipping (Exondys 51), exon 53 skipping (Vyondys 53 and Vilteps[®]), or exon 45 skipping

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(Amondys 45) confirmed by genetic testing (ordering physician MUST provide results of genetic testing); **AND**

- b. Therapy is prescribed by or in consultation with a physician who specializes in the treatment of DMD; **AND**
- c. Baseline age-appropriate motor function and pulmonary function tests have been performed; **AND**
- d. The individual is only requesting one DMD gene-based exon-skipping therapy; **AND**
- e. The physician will follow all FDA recommendations for dosing, administration, and monitoring.

2. **Reauthorization**

Continuation of treatment with exon-skipping therapies may be considered medically necessary at 6-month intervals with documentation from the treating provider confirming that the exon skipping therapy is still considered medically necessary.

Note: There is currently no established efficacy for concomitant therapy with two or more DMD gene-based exon-skipping therapies. Requests for treatment with more than one agent will be reviewed on a case-by-case basis.

B. Micro-dystrophin Gene Therapies (Elevidys)

1. **Initial Authorization**

Gene-based micro-dystrophin therapy Elevidys (delandistrogene moxeparvovec-rokl) for DMD may be considered medically necessary when the following criteria are met:

- a. The individual has a diagnosis of DMD with a mutation in the DMD gene confirmed by genetic testing (ordering physician MUST provide results of genetic testing); **AND**
- b. The individual does not have a deletion in exon 8 and/or exon 9 in the DMD gene; **AND**
- c. The individual is at least 4 years of age; **AND**
- d. The individual does not have an elevated anti-AAVrh74 total binding antibody titer \geq 1:400; **AND**
- e. The individual has not received Elevidys in the past; **AND**
- f. Elevidys is prescribed by or in consultation with a physician who specializes in the treatment of DMD; **AND**
- g. The physician will follow all FDA recommendations for dosing, administration, and monitoring for Elevidys.

2. **Reauthorization**

Elevidys (delandistrogene moxeparvovec-rokl) is a one-time therapy; more than one administration of Elevidys is considered investigational and not medically necessary.

Investigational and Not Medically Necessary

Any other indication for the use of Exondys 51, Vyondys 53, Viltepso, Amondys 45 and Elevidys is considered investigational and not medically necessary.

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NOTE: EPSDT Special Provision

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

PROCEDURE

Prior authorization is required. Coverage determinations will be based upon a review of requested and/or submitted case-specific information.

The following information is needed to review requests for the above therapies:

1. Fully completed State of Connecticut, Department of Social Services HUSKY Health Program Gene Therapy for DMD Prior Authorization Request form (to include physician’s order and signature);
2. Results of genetic testing confirming mutation in the DMD gene (initial authorization requests);
3. Baseline age-appropriate motor function and pulmonary function tests (initial authorization requests);
4. Letter from ordering physician documenting the benefits patient is receiving from treatment (reauthorization requests); and
5. Other information as requested by CHNCT.

Requesting Authorization

Requests must be submitted by the ordering physician and faxed to the number listed on the request form. Questions regarding this form should be directed to the HUSKY Health Program Utilization Management Department at 1.800.440.5071 (select option for medical authorizations).

EFFECTIVE DATE

This Policy for individuals covered under the HUSKY Health Program is effective February 1, 2020.

LIMITATIONS

Not Applicable

CODES:

Code	Definition
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose
J1426	Injection, casimersen, 10mg
J1427	Injection, viltolarsen, 10mg
J1428	Injection, eteplirsen, 10 mg
J1429	Injection, golodirsen, 10mg

DEFINITIONS

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1. **HUSKY A:** Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
2. **HUSKY B:** Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children's Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
3. **HUSKY C:** Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.
4. **HUSKY D:** Connecticut residents who are ages 19-64 without dependent children and who: (1) do not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).
5. **HUSKY Health Program:** The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.
6. **HUSKY Limited Benefit Program or HUSKY, LBP:** Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.
7. **Medically Necessary or Medical Necessity:** (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.
8. **Prior Authorization:** A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested service is medically necessary.

ADDITIONAL RESOURCES AND REFERENCES:

1. AMONDYS 45 [Product Information]. Cambridge, Mass. Sarepta Therapeutics, Inc. Revised July 2024. [https://amondys45.com/Amondys45_\(casimersen\)_Prescribing_Information.pdf](https://amondys45.com/Amondys45_(casimersen)_Prescribing_Information.pdf).
2. A Multicenter, Randomized, Double-Blind, Placebo-Controlled Trial for Duchenne Muscular Dystrophy Using SRP-9001. ClinicalTrials.gov identifier: NCT03769116. Updated September 15, 2023. Accessed September 21, 2023. <https://classic.clinicaltrials.gov/ct2/show/NCT03769116>.
3. A Phase 3 Multinational, Randomized, Double-Blind, Placebo-Controlled Systemic Gene Delivery Study to Evaluate the Safety and Efficacy of SRP-9001 in Subjects With Duchenne Muscular Dystrophy (EMBARC). ClinicalTrials.gov identifier: NCT05096221. Updated September 8, 2023. Accessed September 21, 2023. <https://classic.clinicaltrials.gov/ct2/show/NCT05096221>.
4. Anthony K, Feng L, Arechavala-Gomez V, et al. Exon skipping quantification by quantitative reverse-transcription polymerase chain reaction in Duchenne muscular dystrophy patients treated

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5. Birnkrant DJ, Bushby K, Bann CM, et al. Diagnosis and management of Duchenne muscular dystrophy, part 1: diagnosis, and neuromuscular, rehabilitation, endocrine, and gastrointestinal and nutritional management [published correction appears in *Lancet Neurol*. 2018 Apr 4;:]. *Lancet Neurol*. 2018;17(3):251-267. doi:10.1016/S1474-4422(18)30024-3
 6. Bushby K, Finkel R, Birnkrant DJ, et al. Diagnosis and management of Duchenne muscular dystrophy, part 1: diagnosis, and pharmacological and psychosocial management. *Lancet Neurol*. 2010;9(1):77-93. doi:10.1016/S1474-4422(09)70271-6
 7. Bushby K, Finkel R, Birnkrant DJ, et al. Diagnosis and management of Duchenne muscular dystrophy, part 2: implementation of multidisciplinary care [published correction appears in *Lancet Neurol*. 2010 Mar;9(3):237]. *Lancet Neurol*. 2010;9(2):177-189. doi:10.1016/S1474-4422(09)70272-8
 8. Clemens PR, Rao VK, Connolly AM, et al. Long-Term Functional Efficacy and Safety of Viltolarsen in Patients with Duchenne Muscular Dystrophy. *J Neuromuscul Dis*. 2022;9(4):493-501. doi:10.3233/JND-220811
 9. Clemens PR, Rao VK, Connolly AM, et al. Safety, Tolerability, and Efficacy of Viltolarsen in Boys With Duchenne Muscular Dystrophy Amenable to Exon 53 Skipping: A Phase 2 Randomized Clinical Trial [published correction appears in doi: 10.1001/jamaneurol.2020.2025]. *JAMA Neurol*. 2020;77(8):982-991. doi:10.1001/jamaneurol.2020.1264
 10. ClinicalTrials.gov. Study of SRP-4045 and SRP-4053 in DMD patients (ESSENCE). Available at: <https://clinicaltrials.gov/ct2/show/NCT02500381>. Accessed on March 4, 2021.
 11. Darras BT. Duchenne and Becker muscular dystrophy: glucocorticoid and disease-modifying treatment. In: UpToDate, Patterson MC, Dashe JF (Eds), Wolters Kluwer. Updated August 7, 2024. Accessed August 23, 2024.
 12. Elevidys [package insert]. Cambridge, MA: Sarepta Therapeutics, Inc.; Revised June 2024
 13. Exondys 51 [Product Information]. Cambridge, MA. Sarepta Therapeutics, Inc. Revised January 2022. <https://www.exondys51.com/modules/exondys/files/EXONDYS51PI.pdf>
 14. Frank DE, Mercuri E, Servais, L, et al. Golodirsén induces exon skipping leading to sarcolemmal dystrophin expression in patients with genetic mutations amenable to exon 53 skipping. Poster presented at: Annual Clinical Genetics Meeting of the American College of Medical Genetics and Genomics; April 2-6, 2019; Seattle, WA
 15. Institute for Clinical and Economic Review (ICER). Deflazacort, eteplirsén, and golodirsén for Duchenne muscular dystrophy: Effectiveness and value: Evidence Report. July 11, 2019. https://icer-review.org/wpcontent/uploads/2018/12/ICER_DMD_Evidence_Report_071119.pdf.
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 17. Mendell JR, Goemans N, Lowes LP, et al. Longitudinal effect of eteplirsén versus historical control on ambulation in Duchenne muscular dystrophy. *Ann Neurol*. 2016;79(2):257-271. doi:10.1002/ana.24555
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22. Muntoni F, Frank DE, Sardone V, et al. SRP-4053 induces exon skipping leading to sarcolemmal dystrophin expression in Duchenne muscular dystrophy patients amenable to exon 53 skipping. Poster presented at: 22nd International Annual Congress of the World Muscle Society; October 3-7 2017; Saint Malo, France.
23. Sarepta Therapeutics, Inc. Study of SRP-4045 and SRP-4053 in DMD patients (ESSENCE). ClinicalTrials.gov Identifier: NCT02500381. Bethesda, MD: National Library of Medicine; July 8, 2020.
24. Study to Assess the Efficacy and Safety of Viltolarsen in Ambulant Boys with DMD (RACER53) <https://clinicaltrials.gov/ct2/show/NCT04060199?term=viltolarsen&draw=2&rank=1>.
25. Viltepso [Product Information]. Paramus, NJ. NS Pharma, Inc. Revised March 2021. <https://www.viltepso.com/prescribing-information>
26. Vyondys 53 [Product Information]. Cambridge, MA. Sarepta Therapeutics, Inc. Revised June 2024. [https://www.vyondys53.com/Vyondys53_\(golodirsén\)_Prescribing_Information.pdf](https://www.vyondys53.com/Vyondys53_(golodirsén)_Prescribing_Information.pdf)
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PUBLICATION HISTORY

Status	Date	Action Taken
Original publication	December 2020	Approved at the October 28, 2020 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on December 21, 2020. Approved by DSS on January 7, 2021.
Update	March 2021	Title change. Added coverage guidelines for AMONDYS-45, a new therapy for individuals with DMD that is amenable to exon 45 skipping. Coding update. Changes approved at the March 10, 2021 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 15, 2021. Approved by DSS on March 22, 2021.
Update	June 2021	New code C9075 - casimersen, 10mg added. Code effective July 1, 2021. Approved by DSS on July 2, 2021.
Review	June 2022	Reviewed and approved without changes at the June 8, 2022 CHNCT Medical Reviewer meeting. Reviewed and approved without changes by the CHNCT Clinical Quality Subcommittee on June 20, 2022. Approved by DSS on July 5, 2022.
Update	September 2023	Added elevidys to the policy. Minor formatting and grammatical changes made, and additional references added. Reviewed and approved at the CHNCT Medical Reviewer meeting October 11, 2023. Reviewed and approved by the CHNCT Clinical Quality Subcommittee on December 18, 2023. Approved by DSS on January 03, 2023.

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Update	October 2024	Updated age and ambulation eligibility criteria for elevidys based on updated FDA indication. Removed requirement for corticosteroid regimen for both types of gene therapy. Updated verbiage in exon-skipping therapy reauthorization criteria. Added J1413 code, removed J3590. Updated references. Changes approved at the CHNCT Medical Reviewer meeting October 9, 2024. Approved by the CHNCT Clinical Quality Subcommittee on December 16, 2024. Approved by DSS on December 27, 2024.
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