

# Tegsedi® (inotersen) (Subcutaneous)

Document Number: IC-0401

**Last Review Date: 09/04/2025**

**Date of Origin: 10/30/2018**

**Dates Reviewed: 10/2018, 10/2019, 10/2020, 10/2021, 10/2022, 10/2023, 08/2024, 07/2025, 09/2025**

## I. Length of Authorization

- Initial: Prior authorization validity will be provided initially for 6 months.
- Renewal: Prior authorization validity may be renewed annually thereafter.

## II. Dosing Limits

**Max Units (per dose and over time) [HCPCS Unit]:**

- 284 mg every 7 days

## III. Initial Approval Criteria <sup>1</sup>

Prior authorization validity is provided in the following conditions:

- Patient is at least 18 years of age; **AND**

**Universal Criteria <sup>1</sup>**

- Patient has a platelet count of  $\geq 100 \times 10^9/L$ ; **AND**
- Patient has a baseline urine protein to creatinine ratio (UPCR) of  $< 1000 \text{ mg/g}$  and UPCR will be monitored every 2 weeks during treatment; **AND**
- Patient is receiving supplementation with vitamin A at the recommended daily allowance; **AND**
- Must not be used in combination with other transthyretin (TTR) reducing or stabilizing agents (e.g., patisiran, tafamidis, vutrisiran, eplontersen, etc.); **AND**

**Polyneuropathy due to Hereditary Transthyretin-Mediated (hATTR) Amyloidosis †  $\Phi$  <sup>1,5,6</sup>**

- Patient has a definitive diagnosis of hATTR amyloidosis as documented in a proband with suggestive findings (including imaging or histopathology findings of amyloidosis) and a heterozygous pathogenic (or likely pathogenic) variant in *TTR* identified by molecular genetic testing; **AND**
- Used for the treatment of polyneuropathy as demonstrated by at least TWO of the following criteria:
  - Subjective patient symptoms are suggestive of neuropathy
  - Abnormal nerve conduction studies are consistent with polyneuropathy
  - Abnormal neurological examination is suggestive of neuropathy; **AND**

- Patient’s peripheral neuropathy is attributed to hATTR and other causes of neuropathy have been excluded; **AND**
- Baseline in strength/weakness has been documented using an objective clinical measuring tool (e.g., Medical Research Council (MRC) muscle strength, etc.); **AND**
- Patient has not been the recipient of an orthotopic liver transplant (OLT)

† FDA Approved Indication(s); ‡ Compendia Recommended Indication(s); Ⓞ Orphan Drug

#### IV. Renewal Criteria <sup>1,5,6</sup>

Prior authorization validity may be renewed based upon the following criteria:

- Patient continues to meet the universal and indication specific criteria identified in section III; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: stroke and cervicocephalic arterial dissection, ocular symptoms related to vitamin A deficiency (e.g., night blindness), severe thrombocytopenia, glomerulonephritis and renal toxicity, liver injury, serious inflammatory and immune adverse reactions, hypersensitivity reactions/antibody formation, etc.; **AND**
- Disease response compared to pre-treatment baseline as evidenced by stabilization or improvement in one or more of the following:
  - Signs and symptoms of neuropathy
  - MRC muscle strength

#### V. Dosage/Administration <sup>1</sup>

Indication	Dose
hATTR polyneuropathy	Administer 284 mg subcutaneously once weekly.

#### VI. Billing Code/Availability Information

HCPCS code:

- J3490 – Unclassified drugs
- C9399 – Unclassified drugs or biologicals

NDC:

- Tegsedi 284 mg/1.5 mL single-dose prefilled syringe: 72126-0007-xx

#### VII. References

1. Tegsedi [package insert]. Waltham, MA; Sobi, Inc., January 2024. Accessed May 2025.

2. Benson MD, Waddington-Cruz M, Berk JL, et al. Inotersen Treatment for Patients with Hereditary Transthyretin Amyloidosis. *N Engl J Med*. 2018 Jul 5;379(1):22-31. doi: 10.1056/NEJMoa1716793.
3. Waddington-Cruz M, Ackermann EJ, Polydefkis M, H, et al. Hereditary transthyretin amyloidosis: baseline characteristics of patients in the NEURO-TTR trial. *Amyloid*. 2018 Aug 31:1-9. doi: 10.1080/13506129.2018.1503593.
4. Ando Y, Coelho T, Berk JL, et al. Guideline of transthyretin-related hereditary amyloidosis for clinicians. *Orphanet J Rare Dis*. 2013;8:31.
5. Sekijima Y, Nakamura K. Hereditary Transthyretin Amyloidosis. In: Adam MP, Feldman J, Mirzaa G, et al., editors. *GeneReviews®* [Internet]. Seattle (WA): University of Washington, Seattle; 1993–2025. Initial Posting: November 5, 2001; Last Update: May 30, 2024. Accessed May 29, 2025. <https://www.ncbi.nlm.nih.gov/books/NBK1194/>.
6. Luigetti M, Romano A, DiPaolantonio A, et al. Diagnosis and Treatment of Hereditary Transthyretin Amyloidosis (hATTR) Polyneuropathy: Current Perspectives on Improving Patient Care. *Ther Clin Risk Manag*. 2020; 16: 109–123. Published online 2020 Feb 21. doi: 10.2147/TCRM.S219979.

## Appendix A – Non-Quantitative Treatment Limitations (NQL) Factor Checklist

Non-quantitative treatment limitations (NQLs) refer to the methods, guidelines, standards of evidence, or other conditions that can restrict how long or to what extent benefits are provided under a health plan. These may include things like utilization review or prior authorization. The utilization management NQL applies comparably, and not more stringently, to mental health/substance use disorder (MH/SUD) Medical Benefit Prescription Drugs and medical/surgical (M/S) Medical Benefit Prescription Drugs. The table below lists the factors that were considered in designing and applying prior authorization to this drug/drug group, and a summary of the conclusions that Prime’s assessment led to for each.

Factor	Conclusion
Indication	Yes: Consider for PA
Safety and efficacy	Yes: Consider for PA
Potential for misuse/abuse	No: PA not a priority
Cost of drug	Yes: Consider for PA

## Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
E85.1	Neuropathic hereditary amyloidosis

## Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

The preceding information is intended for non-Medicare coverage determinations. Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15,

§50 Drugs and Biologicals. In addition, National Coverage Determinations (NCDs) and/or Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. Local Coverage Articles (LCAs) may also exist for claims payment purposes or to clarify benefit eligibility under Part B for drugs which may be self-administered. The following link may be used to search for NCD, LCD, or LCA documents:

<https://www.cms.gov/medicare-coverage-database/search.aspx>. Additional indications, including any preceding information, may be applied at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCA/LCD): N/A

<b>Medicare Part B Administrative Contractor (MAC) Jurisdictions</b>		
<b>Jurisdiction</b>	<b>Applicable State/US Territory</b>	<b>Contractor</b>
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC