UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 2155-7
Program	Prior Authorization/Medical Necessity
Medication	Tegsedi® (inotersen)
P&T Approval Date	11/2018, 11/2019, 11/2020, 11/2021, 11/2022, 11/2023, 11/2024
Effective Date	2/1/2025

1. Background:

Tegsedi (inotersen) is a transthyretin-directed antisense oligonucleotide indicated for treatment of the polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults.

2. Coverage Criteria [a]:

A. Hereditary transthyretin-mediated (hATTR) amyloidosis with polyneuropathy

1. **Initial Authorization**

a. **Tegsedi** will be approved based on **all** of the following criteria:

(1) **Both** of the following:

(a) Diagnosis of hATTR amyloidosis with polyneuropathy
(b) Documentation that the patient has a pathogenic TTR mutation (e.g., V30M)

-AND-

(2) Prescribed by or in consultation with a neurologist

-AND-

(3) Documentation of **one** of the following:

(a) Patient has a baseline polyneuropathy disability (PND) score ≤ IIIb
(b) Patient has a baseline FAP Stage 1 or 2
(c) Patient has a baseline neuropathy impairment (NIS) score ≥ 10 and ≤ 130

-AND-

(4) Patient has not had a liver transplant

-AND-

(5) Presence of clinical signs and symptoms of the disease (e.g., peripheral sensorimotor polyneuropathy, autonomic neuropathy, motor disability, etc.)

-AND-

(6) Patient is not receiving Tegsedi in combination with **either** of the following:

(a) Oligonucleotide agents [e.g., Onpattro (patisiran), Amvuttra (vutrisiran)]
(b) Tafamidis (e.g., Vyndaqel, Vyndamax)

Authorization of therapy will be issued for 12 months.

2. **Reauthorization**

a. **Tegsedi** will be approved based on **both** of the following criteria:

(1) Documentation that the patient has experienced a positive clinical response to Tegsedi therapy (e.g., improved neurologic impairment, motor function, quality of life, slowing of disease progression, etc.)

-AND-

(2) Patient is not receiving Tegsedi in combination with **either** of the following:

(a) Oligonucleotide agents [e.g., Onpattro (patisiran), Amvuttra (vutrisiran)]
(b) Tafamidis (e.g., Vyndaqel, Vyndamax)

Authorization of therapy will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Programs:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Tegsedi [package insert]. Boston, MA: Akcea Therapeutics, Inc.; January 2024.
2. Coutinho P, Martins da Silva A, Lopes Lima J, Resende Barbosa A. (1980) Forty years of experience with type I amyloid neuropathy. Review of 483 cases. In: Glenner G., Costa P., de Freitas A., editors (eds.), Amyloid and Amyloidosis. Amsterdam: Execerpta Medica, pp. 88–98
3. Yamamoto S, Wilczek H, Nowak G, et al. Liver transplantation for familial amyloidotic polyneuropathy (FAP): a single-center experience over 16 years. Am J Transplant. 2007 Nov;7(11):2597-604. https://clinicaltrials.gov/ct2/show/NCT02586805. Accessed October 8, 2018.
4. Koike H, Misu K, Ikeda S, et al. Type I (transthyretin Met30) familial amyloid polyneuropathy in Japan: early- vs late-onset form. Arch Neurol. 2002 Nov;59(11):1771-6.

5. Koike H, Tanaka F, Hashimoto R, et al. Natural history of transthyretin Val30Met familial amyloid polyneuropathy: analysis of late-onset cases from non-endemic areas. J Neurol Neurosurg Psychiatry. 2012 Feb;83(2):152-8.
6. Institute for Clinical and Economic Review: Draft Evidence Report - Inotersen and Patisiran for Hereditary Transthyretin Amyloidosis: Effectiveness and Value. July 20, 2018.
7. 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.
8. Ionis Pharmaceuticals. Efficacy and Safety of Inotersen in Familial Amyloid Polyneuropathy. In: ClinicalTrials.gov [Internet]. Bethesda (MD): National Library of Medicine (US). 2000- [cited 2018 October 8]. Available from: https://clinicaltrials.gov/show/NCT01737398. NLM Identifier: NCT01737398.

Program	Prior Authorization/Medical Necessity - Tegsedi™ (inotersen)
Change Control	
11/2018	New program.
11/2019	Annual review. Updated references.
11/2020	Annual review. Added examples of tafamidis products but no change to clinical intent. Updated references.
11/2021	Annual review with no change to clinical criteria. Updated reference.
11/2022	Annual review. Added Amvuttra (vutrisiran) as an example of not to be used in combination with no change in clinical intent. Updated reference.
11/2023	Annual review. Simplified reauthorization criteria to only require positive clinical response and not used in combination with other treatment medications.
11/2024	Annual review with no changes to clinical criteria.