

SPECIALTY GUIDELINE MANAGEMENT

AMVUTTRA (vutrisiran)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication

Amvuttra is indicated for the treatment of the polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults.

All other indications are considered experimental/investigational and not medically necessary.

II. DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review:

A. Initial requests:

1. Testing or analysis confirming a mutation of the TTR gene
2. Medical record documentation confirming the member demonstrates signs and symptoms of polyneuropathy

B. Continuation requests: Chart notes or medical record documentation supporting a positive clinical benefit of Amvuttra therapy

III. PRESCRIBER SPECIALTIES

This medication must be prescribed by or in consultation with a neurologist, geneticist, or physician specializing in the treatment of amyloidosis.

IV. CRITERIA FOR INITIAL APPROVAL

Polyneuropathy of Hereditary Transthyretin-mediated Amyloidosis

Authorization of 12 months may be granted for treatment of polyneuropathy of hereditary transthyretin-mediated amyloidosis (also called transthyretin-type familial amyloid polyneuropathy [ATTR-FAP]) when all of the following criteria are met:

- A. The diagnosis is confirmed by detection of a mutation of the TTR gene.
- B. Member exhibits clinical manifestations of ATTR-FAP (e.g., amyloid deposition in biopsy specimens, TTR protein variants in serum, progressive peripheral sensory-motor polyneuropathy).
- C. The member is not a liver transplant recipient.
- D. The requested medication will not be used in combination with inotersen (Tegsedi), patisiran (Onpattro) or tafamidis (Vyndaqel, Vyndamax).

Reference number(s)
5491-A

V. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for the continued treatment of ATTR-FAP when all of the following criteria are met:

- A. The member must have met all initial authorization criteria.
- B. The member must have demonstrated a beneficial response to treatment with Amvuttra therapy compared to baseline (e.g., improvement of neuropathy severity and rate of disease progression as demonstrated by the modified Neuropathy Impairment Scale+7 (mNIS+7) composite score, the Norfolk Quality of Life-Diabetic Neuropathy (QoL-DN) total score, polyneuropathy disability (PND) score, FAP disease stage, manual grip strength).

REFERENCES

1. Amvuttra [package insert]. Cambridge, MA: Alnylam Pharmaceuticals, Inc.; June 2022.
2. Ando Y, Coelho T, Berk JL, Cruz MW, Ericzon BG, Ikeda S, Lewis WD, Obici L, Planté-Bordeneuve V, Rapezzi C, et al. Guideline of transthyretin-related hereditary amyloidosis for clinicians. *Orphanet J Rare Dis.* 2013; 8:31.
3. Sekijima Y. Hereditary Transthyretin Amyloidosis. 2001 Nov 5 [Updated 2021 June 17]. In: Adam MP, Ardinger HH, Pagon RA, et al., editors. *GeneReviews®* [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2022. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK1194/>. Accessed March 16, 2023.