Clinical Policy: Vutrisiran (Amvuttra)

Reference Number: LA.PHAR.550
Effective Date: 09.29.23
Last Review Date: 06.23.25~~10.10.24~~ Coding Implications
Line of Business: Medicaid Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

****Please note: This policy is for medical benefit****

Description
Vutrisiran (Amvuttra™) is a transthyretin-directed small interfering ribonucleic acid (RNA).

FDA Approved Indication(s)
Amvuttra is indicated for the treatment of ~~the polyneuropathy of hereditary transthyretin-mediated (hATTR) amyloidosis in adults.~~:

- The polyneuropathy of hereditary transthyretin-mediated amyloidosis (hATTR) in adults
- The cardiomyopathy of wild-type or hereditary ATTR (ATTR-CM) in adults to reduce cardiovascular mortality, cardiovascular hospitalizations, and urgent heart failure visits.

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 Louisiana Healthcare Connections® that Amvuttra is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Polyneuropathy of Hereditary Transthyretin-Mediated Amyloidosis (must meet all~~):~~ **):***

** See Section B below for transthyretin amyloid cardiomyopathy*

1. Diagnosis of hATTR with polyneuropathy;
2. Prescribed by or in consultation with a neurologist;
3. Age ≥ 18 years;
4. Documentation confirms presence of a transthyretin (TTR) mutation;
5. Biopsy is positive for amyloid deposits or medical justification is provided as to why treatment should be initiated despite a negative biopsy or no biopsy;
6. Member has not had a prior liver transplant;
~~7. Member has not received prior treatment with Onpattro®, Tegsedi®, or Wainua™;~~
~~8.~~7. Amvuttra is not prescribed concurrently with Onpattro, Tegsedi, or Wainua;
~~9.~~8. Dose does not exceed 25 mg every 3 months.

Approval duration: 6 months

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B. ~~Other diagnoses/indications~~ Transthyretin Amyloid Cardiomyopathy (must meet ~~1 or~~ all)**:**

1. Diagnosis of ATTR-CM;
2. Prescribed by or in consultation with a cardiologist;
3. Age ≥ 18 years;
4. Diagnosis is supported by one of the following (a or b):
   a. Tissue biopsy amyloid protein is identified as transthyretin via mass spectrometry or immunohistochemistry, and (i or ii):
      i. Tissue biopsy is of endomyocardial origin;
      ii. Tissue biopsy is of extra-cardiac origin and echocardiography (Echo), cardiac magnetic resonance imaging (CMR), or positron emission tomography (PET) findings are consistent with cardiac amyloidosis;
   b. Member meets all of the following (i, ii, and iii):
      i. Echo, CMR, or PET findings are consistent with cardiac amyloidosis;
      ~~B.~~ii. Cardiac uptake is Grade 2 or 3 on a radionuclide scan utilizing one of the following radiotracers (1, 2, or 3)**:**
         1) ~~If this drug~~99m technetium (Tc)-labeled 3,3-diphosphono-1,2-propanodicarboxylic acid (DPD);
         2) 99mTc-labeled pyrophosphate (PYP);
         3) 99mTc-labeled hydroxymethylene diphosphonate (HMDP);
      iii. Each of the following laboratory tests is negative for monoclonal protein (1, 2, and 3);
         1) Serum kappa/lambda free light chain ratio analysis;
         2) Serum protein immunofixation;
         3) Urine protein immunofixation;
5. Member has ~~recently~~heart failure of New York Heart Association (NHYA) Class I, II, or III;
6. If member NYHA Class III heart failure, member does not have ATTR Amyloidosis Disease Stage 3 (defined as NT-proBNP > 3,000 ng/L and eGFR < 45 mL/min);
7. Member has one of the following (a or b):
   a. At least 1 prior hospitalization for heart failure;
   b. Current (within the last ~~6 months) undergone a label change (~~30 days) clinical evidence of heart failure (i.e., signs and symptoms, see *Appendix D*);
8. Member has not had a liver transplant;
9. Amvuttra is not prescribed concurrently with Attruby™ or Onpattro®;
10. If member is currently receiving treatment with Vyndaqel®/Vyndamax™ and request is for concurrent use with Amvuttra (i.e., not switching from one agent to another), provider must submit evidence of both of the following (a and b):
    a. Member has experienced and maintained positive response to Vyndaqel/Vyndamax monotherapy following at least 6 months of monotherapy;
    b. Despite Vyndaqel/Vyndamax monotherapy, member continues to require cardiac-related hospitalization;
11. Dose does not exceed 25 mg every 3 months.

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Approval duration: 6 months

C. Other diagnoses/indications (must meet 1 or 2)**:**

~~1.~~a. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to ~~.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to~~ LA.PMN.255

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy LA.PMN.53 ~~for Medicaid~~.

II. Continued Therapy

A. Polyneuropathy of Hereditary Transthyretin-Mediated Amyloidosis (must meet all~~):~~**):***

1. Currently receiving medication via Louisiana Healthcare Connections benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy as evidenced by, including but not limited to, improvement in any of the following parameters: measures of polyneuropathy (e.g., motor strength, sensation, and reflexes), quality of life, motor function, walking ability (e.g., as measured by timed 10-m walk test), and nutritional status (e.g., as evaluated by modified mass index);
3. Member has not had a prior liver transplant;
4. Amvuttra is not prescribed concurrently with Onpattro, Tegsedi, or Wainua;
5. If request is for a dose increase, new dose does not exceed 25 mg every 3 months.

Approval duration: 12 months

B. Transthyretin Amyloid Cardiomyopathy (must meet all)**:**

1. Currently receiving medication via Louisiana Healthcare Connections benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy, including but not limited to improvement or stabilization in any of the following parameters:
   a. Walking ability;
   b. Nutrition (e.g., body mass index);
   c. Cardiac related hospitalization;
   d. Cardiac procedures or laboratory tests (e.g., Holter monitoring, echocardiography, electrocardiogram, plasma BNP or NT-proBNP, serum troponin)
3. Amvuttra is not prescribed concurrently with Attruby or Onpattro;
4. If request is for a dose increase, new dose does not exceed 25 mg every 3 months.

Approval duration: 12 months

C. Other diagnoses/indications (must meet 1 or 2)**:**

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1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255

B.A. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy LA.PMN.53 for Medicaid.

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 policyies – LA.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ATTR-CM: cardiomyopathy of transthyretin-mediated amyloidosis
eGFR: estimated glomerular filtration rate
FDA: Food and Drug Administration
hATTR: hereditary transthyretin-mediated
NT-proBNP: N-terminal pro-B-type natriuretic peptide
RNA: ribonucleic acid
TTR: transthyretin

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

None reported

Appendix D: General Information

- To confirm amyloidosis, the demonstration of amyloid deposits via tissue biopsy is essential. Deposition of amyloid in the tissue can be demonstrated by Congo red staining of biopsy specimens. With Congo red staining, amyloid deposits show a characteristic green birefringence under polarized light; however, negative biopsy results should not be interpreted as excluding the disease.
- DNA sequencing is usually required for genetic confirmation. Current techniques for performing sequence analysis of TTR, the only gene known to be associated with TTR amyloidosis, detect > 99% of disease-causing mutations.
- While signs and symptoms of advanced heart failure are variable, common manifestations of advanced hear failure include exercise intolerance, unintentional weight

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loss, refractory volume overload, recurrent ventricular arrhythmias, as well as hypotension and signs of inadequate perfusion (e.g., low, or narrowed pulse pressure, cool extremities, and mental status changes). Laboratory testing that may reveal signs of advanced heart failure includes indications of poor or worsening renal function, hyponatremia, hypoalbuminemia, congestive hepatopathy, elevated serum natriuretic peptide levels. Pulmonary edema, pleural effusions, and/or pulmonary vascular congestion on chest radiograph are also suggestive of advanced heart failure.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Polyneuropathy of hATTR, ATTR-CM	25 mg SC every three months	25 mg/3 months

VI. Product Availability

Single-dose prefilled syringe: 25 mg/0.5 mL

VII. References

1. Amvuttra Prescribing Information. Cambridge, MA: Alnylam Pharmaceuticals, Inc.; ~~February 2023.~~March 2025. Available at: https://www.alnylam.com/sites/default/files/pdfs/amvuttra-us-prescribing-information.pdf. Accessed ~~February 12, 2024~~March 26, 2025.
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7. Obici L, Polydefkis M, Gonzalez-Duarte A, et al. HELIOS-A: 9-~~Month Results~~month results from the ~~Randomized Treatment Extension Period~~randomized treatment extension period of ~~Vutrisiran~~vutrisiran in ~~Patients~~patients with ~~Hereditary Transthyretin-Mediated Amyloidosis~~hereditary transthyretin-mediated amyloidosis with ~~Polyneuropathy~~polyneuropathy. Available at: https://capella.alnylam.com/wp-

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9. Fontana M, Berk JL, Gillmore JD, et al.; HELIOS-B Trial Investigators and Collaborators. Vutrisiran in patients with transthyretin amyloidosis with cardiomyopathy. N Engl J Med. 2025 Jan 2;392(1):33-44.
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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
J0225	Injection, vutrisiran, 1 mg

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Policy created	05.01.23	08.28.23
Annual review: no significant changes; references reviewed and updated.	03.15.24	05.23.24

CLINICAL POLICY
Vutrisiran

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Added Wainua to list of drugs that should not have been previously received or prescribed concurrently; references reviewed and updated	10.10.24	01.27.25
Annual review: removed criteria "member has not received prior treatment with Onpattro, Tegsedi, or Wainua" per competitor analysis and to allow alternative therapy as a result of Tegsedi market withdrawal; references reviewed and updated; added new indication for ATTR-CM per updated prescribing information.	06.23.25	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to

recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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