Drug Coverage Policy

Effective Date.....10/15/2024
Coverage Policy Number.....IP0624
Policy Title.....Agamree

Muscular Dystrophy – Agamree

- Agamree™ (vamorolone oral suspension – Santhera/Catalyst)

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment and have discretion in making individual coverage determinations. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Cigna Healthcare Coverage Policy

Overview

Agamree, a corticosteroid, is indicated for the treatment of **Duchenne muscular dystrophy** (DMD) in patients ≥ 2 years of age.[1]

Disease Overview

DMD is a rare, progressive X-linked disease resulting from mutation(s) of the DMD gene, also known as the Dystrophin gene.[2,3] Due to the mutation(s), the dystrophin protein, which is key for maintaining the structural integrity of muscle cells, is not produced or very minimally produced. Since this is an X-linked mutation, DMD almost exclusively impacts young boys. DMD is a progressive muscle-weakening disease that affects skeletal, respiratory, and cardiac muscles. It is usually diagnosed in the second or third year of life. Due to progressive decline, most patients die

of cardiac or respiratory complications in the third or fourth decade of life. The incidence of DMD in the US is approximately 1 in 5,000 live male births.

Guidelines
Agamree is not addressed in guidelines. Guidelines from the DMD Care Considerations Working Group (2018) state that glucocorticoids and physical therapy are the mainstays of treatment for DMD.[2-6] Both therapies should be continued after the patient loses ambulation. Guidelines for the use of corticosteroids in DMD are available from the American Academy of Neurology (AAN) [2016, reaffirmed January 2022].[4] The AAN notes that in patients with DMD, prednisone should be used to improve strength and pulmonary function (moderate evidence). Emflaza™ (deflazacort tablets and oral suspension) and prednisone may be used to improve timed motor function, reduce the need for scoliosis surgery, and to delay the onset of cardiomyopathy by 18 years of age (weak evidence). Emflaza may also be used to improve pulmonary function and to delay the age at loss of ambulation by 1.4 to 2.5 years (weak evidence). There is insufficient evidence to support or refute the benefit of prednisone on survival (insufficient evidence). Emflaza may be used to increase survival at 5 and 15 years of follow-up (weak evidence).

Medical Necessity Criteria

Documentation: Documentation is required for use of Agamree as noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and/or other information.

Agamree is considered medically necessary when the following is met:

1. **Duchenne Muscular Dystrophy.** Approve for 1 year if the patient meets ONE of the following (A or B):
   - **A)** Initial Therapy. Approve if the patient meets ALL of the following (i, ii, iii, and iv):
     - **i.** Patient is ≥ 2 years of age; AND
     - **ii.** Patient's diagnosis of Duchenne Muscular Dystrophy is confirmed by genetic testing with a confirmed pathogenic variant in the dystrophin gene **[documentation required]** ; AND
     - **iii.** Patient meets ONE of the following (a or b):
       - **a)** Patient has tried prednisone or prednisolone for ≥ 6 months **[documentation required]** AND according to the prescriber, the patient has had at least ONE of the following significant intolerable adverse effects [1, 2, 3, or 4]:
         - **1)** Cushingoid appearance **[documentation required]**; OR
         - **2)** Central (truncal) obesity **[documentation required]**; OR
         - **3)** Undesirable weight gain defined as ≥ 10% body weight increase over a 6-month period **[documentation required]**; OR
         - **4)** Diabetes and/or hypertension that is difficult to manage according to the prescriber **[documentation required]**; OR
       - **b)** According to the prescriber, the patient has experienced a severe behavioral adverse event while on prednisone or prednisolone therapy that has or would require a prednisone or prednisolone dose reduction **[documentation required];** AND
     - **iv.** The medication is prescribed by or in consultation with a physician who specializes in the treatment of Duchenne muscular dystrophy and/or neuromuscular disorders.
   - **B)** Patient is Currently Receiving Agamree. Approve if the patient meets ALL of the following (i, ii, iii, and iv):
     - **i.** Patient is ≥ 2 years of age; AND
     - **ii.** Patient has tried prednisone or prednisolone **[documentation required]**; AND

iii. According to the prescriber, the patient has responded to or continues to have improvement or benefit from Agamree therapy **[documentation required]**; AND
Note: Examples of improvement or benefit from Agamree therapy would include improvements in motor function (e.g., time from supine to standing, time to climb four stairs, time to run or walk 10 meters, 6-minute walk test), improvement in muscle strength, and improved pulmonary function.

iv. The medication is prescribed by or in consultation with a physician who specializes in the treatment of Duchenne muscular dystrophy and/or neuromuscular disorders.

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Conditions Not Covered

Any other use is considered experimental, investigational, or unproven (criteria will be updated as new published data are available).

References

1. Agamree® oral suspension [prescribing information]. Burlington, MA: Santhera/Catalyst; October 2023.
2. 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. *Lancet Neurol*. 2018;17(3):251-267.
3. Birnkrant DJ, Bushby K, Bann CM, et al. Diagnosis and management of Duchenne muscular dystrophy, part 2: respiratory, cardiac, bone health, and orthopaedic management. *Lancet Neurol*. 2018;17(4):347-361.
4. Birnkrant DJ, Bushby K, Bann CM, et al. Diagnosis and management of Duchenne muscular dystrophy, part 3: primary care, emergency medicine, psychological care, and transitions of care across the lifespan. *Lancet Neurol*. 2018;17(5):445-455.
5. Gloss D, Moxley RT III, Ashwal S, Oskoui M. Practice guideline update summary: corticosteroid treatment of Duchenne muscular dystrophy: report of the Guideline Development Subcommittee of the American Academy of Neurology. *Neurology*. 2016;86(5):465-472.
6. Summary of Practice Guidelines for Clinicians. Practice Guideline Update: Corticosteroid Treatment of Duchenne Muscular Dystrophy. Available at: https://www.aan.com/Guidelines/Home/GuidelineDetail/731. Accessed on November 7, 2023.

Revision Details

Type of Revision	Summary of Changes	Date
New	New policy	07/15/2024
Early Annual Revision	**Duchenne Muscular Dystrophy:** **Removed** criteria asking for "muscle biopsy showing the absence of, or marked decrease in, dystrophin protein" for diagnosis confirmation of Duchenne muscular dystrophy. **Added** the requirement that the patient has tried prednisone or prednisolone for	10/15/2024

	≥ 6 months and according to the prescriber, experienced at least one significant intolerable adverse effect: Cushingoid appearance, central (truncal) obesity, undesirable weight gain (≥ 10% body weight increase over 6 months), or difficult-to-manage diabetes and/or hypertension. **Updated** the requirement that the patient has experienced significant adverse effects while on prednisone or prednisolone therapy to now state that "according to the prescriber, the patient has experienced significant a severe behavioral adverse effects event while on prednisone or prednisolone therapy that has or would require a prednisone or prednisolone dose reduction." **Added** "documentation required" for use of Agamree as noted in the criteria.	

The policy effective date is in force until updated or retired.