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Policy Number: C17942-A

Mepsevii (vestronidase alfa-vjbk)

PRODUCTS AFFECTED

Mepsevii (vestronidase alfa-vjbk)

COVERAGE POLICY

Coverage for services, procedures, medical devices, and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.
This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines

Documentation Requirements:
Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive

DIAGNOSIS:
Mucopolysaccharidosis VII (MPS VII, Sly syndrome)

REQUIRED MEDICAL INFORMATION:
This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. If a drug within this policy receives an updated FDA label within the last 180 days, medical necessity for the member will be reviewed using the updated FDA label information along with state and federal requirements, benefit being administered and formulary preferencing. Coverage will be determined on a case-by case basis until the criteria can be updated through Molina Healthcare, Inc. clinical governance. Additional information may be required on a case-by-case basis to allow for adequate review.

A. MUCOPOLYSACCHARIDOSIS VII:
1. Medical record documentation of a diagnosis of Mucopolysaccharidosis VII (MPS VII, Sly syndrome) confirmed by ALL of the following: Elevated urinary glycosaminoglycans (GAGs) at least three times the upper limit of normal (3xULN) AND Enzyme activity assay (beta-glucuronidase deficiency) OR genetic testing (mutation of chromosome 7q21.11) AND At least one of the following clinical signs or symptoms: enlarged liver and spleen, joint limitations,

airway obstructions or pulmonary dysfunction [DOCUMENTATION REQUIRED]
Note: Some members may only have elevated GAGs two times the upper limit of normal (2xULN). Elevated GAGs and two mutations consistent with MPS VII are appropriate to diagnose members with MPS VII when diagnosed through newborn screening or sibling screening.
AND

2. Prescriber attests that the prescribed ERT will be used as monotherapy: NOT to be used concurrently with other medications for Mucopolysaccharidosis
AND
3. Documentation of baseline values for the following (documentation required): [ALL]
(a) Member's weight dated within 1 month of the prior authorization request
NOTE: Member's weight must be provided at time of prior authorization request and for any subsequent dose increases. Requests for amounts above initially authorized limits will require documentation of an updated member weight for review and authorization.
AND
(b)Urinary glycosaminoglycan (uGAG)
AND
(c) (i) Members 6 years or older (one of the following): 6-minute walk test (6-MWT) and/or percent predicted forced vital capacity (FVC). OR
(ii) Members younger than 6 years of age (one of the following): upper airway obstruction during sleep, cardiac status, growth velocity, mental development, FVC, and/or 6-minute walk test

CONTINUATION OF THERAPY:

A. MUCOPOLYSACCHARIDOSIS VII:

1. Prescriber attests (or medical records support) that requested ERT remains for use as monotherapy: NOT to be used concurrently with other MPS drug therapy
AND
2. Documentation of positive response or disease stability to therapy as compared to baseline (prior to therapy):
(a) Decreased urinary glycosaminoglycan (GAG) levels AND
(b) i. 6 years or older (one of the following): 6-minute walk test (6-MWT) and/or percent predicted forced vital capacity (FVC).
OR
ii. Younger than 6 years of age (one of the following): decreased hepatosplenomegaly, improvement in upper airway obstruction during sleep, cardiac status, growth velocity, mental development, FVC, and/or 6-minute walk test
3. Prescriber attests (or medical records support) the absence of severe adverse events or unacceptable toxicity from the drug [e.g., anaphylaxis, severe allergic reactions, etc.)
AND
4. If dose increase, documentation of member's weight dated within 1 month of the prior authorization request [DOCUMENTATION REQUIRED]
NOTE: Member's weight must be provided for any subsequent dose increases. Requests for amounts above initially authorized limits will require documentation of an updated member weight for review and authorization.

DURATION OF APPROVAL:

Initial authorization: 12 months, Continuation of Therapy: 12 months

PRESCRIBER REQUIREMENTS:

Prescribed by, or in consultation with, a board-certified geneticist, metabolic specialist, pediatric neurologist, pediatric developmentalist, endocrinologist, or a physician who specializes in the treatment of lysosomal storage disorders, or a physician experienced in the management of

mucopolysaccharidoses (MPS). Submit consultation notes if applicable. Consultation notes must be submitted for initial request AND at least once annually for continuation of treatment requests.

AGE RESTRICTIONS:
None

QUANTITY:
4 mg/kg of body weight once every 2 weeks

PLACE OF ADMINISTRATION:
The recommendation is that infused medications in this policy will be for pharmacy or medical benefit coverage administered in a place of service that is a non-hospital facility-based location as per the Molina Health Care Site of Care program.

Note: Site of Care Utilization Management Policy applies for Mepsevii (vestronidase alfa-vjbk). For information on site of care
Specialty Medication Administration Site of Care Coverage Criteria (molinamarketplace.com)

DRUG INFORMATION

ROUTE OF ADMINISTRATION:
Intravenous Solution

DRUG CLASS:
Mucopolysaccharidosis VII (MPS VII) – Agents

FDA-APPROVED USES:
Indicated in pediatric and adult patients for the treatment of Mucopolysaccharidosis VII (MPS VII, Sly syndrome) Limitations of Use: The effect of Mepsevii on the central nervous system manifestations of MPS VII has not been determined.

COMPENDIAL APPROVED OFF-LABELED USES:
None

APPENDIX

APPENDIX:
None

BACKGROUND AND OTHER CONSIDERATIONS

BACKGROUND:
Mucopolysaccharidosis VII (Sly syndrome; MPS VII) is an autosomal recessive lysosomal storage disorder (LSD) that is characterized by the deficiency of activity of β-glucuronidase (GUS). GUS is one of the enzymes that are involved in degradation of glycosaminoglycans (GAGs). In GUS deficiency, the GAGs are partially degraded which leads to accumulation of their fragments in the lysosomes of many tissues and eventually cellular and organ dysfunction.3 MPS VII is an inherited, rare genetic condition and impacts less than 150 patients worldwide. The estimated frequency of this disease is 1:300 000–1:2 000000 Many patients may have been missed because of early death in utero.3

MPS VII had a wide range of clinical presentation and disease progression. Most patients have cognitive impairment, hepatosplenomegaly, and skeletal dysplasia. However, affected patients show a wide range of clinical variability. Some patients present with early and severe manifestations whereas other patients might have later onset with normal or near-normal intelligence.[3]

FDA approved Mepsevii in November 2017 based on data from Pharmacokinetic and Pharmacodynamic

Modeling to Optimize the Dose of Vestronidase Alfa, an Enzyme Replacement Therapy for Treatment of Patients with Mucopolysaccharidosis Type VII: Results from Three Trials. These trials evaluated pharmacokinetics and pharmacodynamics in 23 participants with MPS VII to optimize dosing regimen of vestronidase alpha. Participants of this study were adults and children aged 5-35 years with a confirmed by diagnosis of MPS VII (genetic testing, elevated uGAG excretion, apparent clinical signs of lysosomal storage disease). Model-based simulations predicted substantially decreased time duration of serum exposures exceeding the level of K uptake for 4 or8 mg/kg once every 4 weeks dosing, compared with 4 mg/kg once every other week dosing by intravenous infusion, suggesting that given the same total monthly dose, the every other week dosing frequency should result in more efficient delivery to the GUS-deficient tissue cells, and therefore superior treatment efficacy. The observed pharmacological responses showed reduction in urinary GAGs from pretreatment baseline and appeared to have reached the plateau of maximal effect at the 4 mg/kg every other week dose. The clinical evidence of safety and efficacy supported 4 mg/kg every other week dosing regimen of vestronidase alfa for pediatric and adult patients with MPS VII.[2]

CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:
All other uses of Mepsevii (vestronidase alfa-vjbk) are considered experimental/investigational and therefore, will follow Molina's Off- Label policy. Contraindications to Mepsevii (vestronidase afla-vjbk) include: No labeled contraindications.

OTHER SPECIAL CONSIDERATIONS:
BLACK BOX WARNING: Anaphylaxis has occurred with MEPSEVII administration, as early as the first dose (5.1), therefore appropriate medical support should be readily available when MEPSEVII is administered. Closely observe patients during and for 60 minutes after MEPSEVII infusion. Immediately discontinue the MEPSEVII infusion if the patient experiences anaphylaxis

CODING/BILLING INFORMATION

Note: 1) This list of codes may not be all-inclusive. 2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement

HCPCS CODE	DESCRIPTION
J3397	Injection, vestronidase alfa-vjbk, 1mg

AVAILABLE DOSAGE FORMS:
Injection: Mepsevii 10 mg/5 mL (2 mg/mL) in a single-dose vial

REFERENCES

1. Mepsevii [package insert]. Novato, CA: Ultragenyx Pharmaceutical Inc.; December 2020
2. Qi, Yulan et al. "Pharmacokinetic and Pharmacodynamic Modeling to Optimize the Dose of Vestronidase Alfa, an Enzyme Replacement Therapy for Treatment of Patients with Mucopolysaccharidosis Type VII: Results from Three Trials." Clinical pharmacokinetics vol.58,5(2019): 673-683. doi:10.1007/s40262-018-0721-y
3. Montano AM, Lock-Hock N, Steiner RD, et al Clinical course of sly syndrome (mucopolysaccharidosis type VII) Journal of Medical Genetics2016;53:403-418.
4. Wang, R., Bodamer, O., Watson, M., & Wilcox, W. (2011). Lysosomal storage diseases: Diagnostic confirmation and management of presymptomatic individuals. Genetics In Medicine,13(5), 457-484. doi: 10.1097/gim.0b013e318211a7e1

SUMMARY OF REVIEW/REVISIONS	DATE
REVISION- Notable revisions: Required Medical Information Continuation of Therapy Contraindications/Exclusions/Discontinuation Other Special Considerations	Q3 2022
Q2 2022 Established tracking in new format	Historical changes on file