Zolgensma® (onasemnogene abeparvovec-xioi)
(Intravenous)

Document Number: IC-0468

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I. Length of Authorization

Coverage will be provided for one dose and may not be renewed.

II. Dosing Limits

A. Quantity Limit (max daily dose) [NDC Unit]:

- 1 kit (based on weight chart below)

B. Max Units (per dose and over time) [HCPCS Unit]:

- 1 kit (based on weight chart below)

III. Initial Approval Criteria

Submission of medical records (chart notes) related to the medical necessity criteria is REQUIRED on all requests for authorizations. Records will be reviewed at the time of submission. Please provide documentation related to diagnosis, step therapy, and clinical markers (i.e. genetic and mutational testing) supporting initiation when applicable. Medical records may be submitted via direct upload through the PA web portal or by fax.

Coverage is provided in the following conditions:

Spinal Muscular Atrophy (SMA) † Φ [1-11]

- Patient must be less than 2 years of age; **AND**
- Patient has a diagnosis of 5q spinal muscular atrophy confirmed by either bi-allelic deletion or dysfunctional point mutation of the *SMN1* gene; **AND**
- Patient must have SMA phenotype 1 confirmed by having 1-3 copies of the SMN2 gene; **AND**
- Patient must have a baseline anti-AAV9 antibody titer of ≤ 1:50 measured by ELISA; **AND**

- Baseline liver function will be assessed prior to initiating therapy and will continue to be monitored for at least 3 months after therapy; **AND**
- Used concomitantly with systemic corticosteroids (see dosage/administration below); **AND**
- Patient does not have advanced disease (complete limb paralysis, permanent ventilation support, etc.); **AND**
- Will not be used in combination with other agents for SMA (e.g., nusinersen, risdiplam, etc.)

† FDA Approved Indication(s); ‡ Compendium Recommended Indication(s); Φ Orphan Drug

IV. Renewal Criteria [1]

Coverage cannot be renewed.

V. Dosage/Administration [1]

Indication	Dose
SMA1	<u>Preparing for Administration:</u> • One day prior to Zolgensma infusion, begin administration of systemic corticosteroids equivalent to oral prednisolone at 1 mg/kg of body weight per day for a total of 30 days <u>Zolgensma Infusion:</u> • Administer as a single-dose intravenous infusion through a venous catheter • Administer as a slow infusion over 60 minutes • The recommended dose of Zolgensma is 1.1×10^{14} vector genomes per kilogram (vg/kg) of body weight
<u>NOTE:</u> • Zolgensma is shipped frozen at ≤ -60 °C. Store in a refrigerator at in a refrigerator at 2°C to 8°C (36°F to 46°F) and thaw prior to infusion. DO NOT RE-FREEZE. Must be used within 14 days of receipt. • Zolgensma is an adeno-associated virus vector-based gene therapy. Follow precautions for viral vector shedding for one month after the infusion. • For single-dose intravenous infusion only.	

VI. Billing Code/Availability Information

<u>HCPCS code:</u>

- J3399 – Injection, onasemnogene abeparvovec-xioi, per treatment, up to $5x10^{15}$ vector genomes; 1 billable unit = 1 treatment, up to $5x10^{15}$ vector genomes

<u>NDC:</u>

Zolgensma kit sizes:

Patient Weight (kg)	NDC	Patient Weight (kg)	NDC
2.6 – 3.0	71894-0120	12.1 – 12.5	71894-0139
3.1 – 3.5	71894-0121	12.6 – 13.0	71894-0140
3.6 – 4.0	71894-0122	13.1 – 13.5	71894-0141

4.1 – 4.5	71894-0123	13.6 – 14.0	71894-0142
4.6 – 5.0	71894-0124	14.1 – 14.5	71894-0143
5.1 – 5.5	71894-0125	14.6 – 15.0	71894-0144
5.6 – 6.0	71894-0126	15.1 – 15.5	71894-0145
6.1 – 6.5	71894-0127	15.6 – 16.0	71894-0146
6.6 – 7.0	71894-0128	16.1 – 16.5	71894-0147
7.1 – 7.5	71894-0129	16.6 – 17.0	71894-0148
7.6 – 8.0	71894-0130	17.1 – 17.5	71894-0149
8.1 – 8.5	71894-0131	17.6 – 18.0	71894-0150
8.6 – 9.0	71894-0132	18.1 – 18.5	71894-0151
9.1 – 9.5	71894-0133	18.6 – 19.0	71894-0152
9.6 – 10.0	71894-0134	19.1 – 19.5	71894-0153
10.1 – 10.5	71894-0135	19.6 – 20.0	71894-0154
10.6 – 11.0	71894-0136	20.1 – 20.5	71894-0155
11.1 – 11.5	71894-0137	20.6 – 21.0	71894-0156
11.6 – 12.0	71894-0138		

VII. References

1. Zolgensma [package insert]. Bannockburn, IL; AveXis, Inc., February 2023. Accessed July 2023.
2. Mendell JR, Al-Zaidy S, Shell R. Single-dose gene-replacement therapy for spinal muscular atrophy. N Engl J Med. 2017;377(18):1713-1722. doi: 10.1056/NEJMoa1706198.
3. Wang CH, Finkel RS, Bertini ES, et al. Consensus statement for standard of care in spinal muscular atrophy. J Child Neurol. 2007 Aug;22(8):1027-49.
4. Prior TW, Finanger E. Spinal muscular atrophy. GeneReviews. www.ncbi.nlm.nih.gov/books/NBK1352/. Initial Posting: February 24, 2000; Last Revision: December 3, 2022. Accessed on July 10, 2023.
5. Dabbous O, Maru B, Jansen JP, et al. Survival, Motor Function, and Motor Milestones: Comparison of AVXS-101 Relative to Nusinersen for the Treatment of Infants with Spinal Muscular Atrophy Type 1. Adv Ther. 2019 May;36(5):1164-1176.
6. Al-Zaidy S, Pickard AS, Kotha K, et al. Health outcomes in spinal muscular atrophy type 1 following AVXS-101 gene replacement therapy. Pediatr Pulmonol. 2019 Feb;54(2):179-185.
7. Al-Zaidy SA, Kolb SJ, Lowes L, et al. AVXS-101 (Onasemnogene Abeparvovec) for SMA1: Comparative Study with a Prospective Natural History Cohort. J Neuromuscul Dis. 2019;6(3):307-317. doi: 10.3233/JND-190403.
8. Lowes LP, Alfano LN, Arnold WD, et al. Impact of age and motor function in a phase 1/2A study of infants with SMA type 1 receiving single-dose gene replacement therapy. Pediatr Neurol. 2019;98:39-45.
9. Day JW, Finkel RS, Chiriboga CA, et al. Onasemnogene abeparvovec gene therapy for symptomatic infantile-onset spinal muscular atrophy in patients with two copies of SMN2

(STR1VE): an open-label, single-arm, multicentre, phase 3 trial. Lancet Neurol. 2021 Apr;20(4):284-293. doi: 10.1016/S1474-4422(21)00001-6. Epub 2021 Mar 17.

10. Mendell JR, Al-Zaidy SA, Lehman KJ, et al. Five-Year Extension Results of the Phase 1 START Trial of Onasemnogene Abeparvovec in Spinal Muscular Atrophy. JAMA Neurol. 2021 May 17;e211272. doi: 10.1001/jamaneurol.2021.1272.
11. (ICER) IfCaER . Spinraza and Zolgensma for Spinal Muscular Atrophy: Effectiveness and Value. Final Evidence Report. April 3, 2019 (Updated May 24, 2019) 2019.

Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
G12.0	Infantile spinal muscular atrophy, type I [Werdnig-Hoffmann]

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD), Local Coverage Articles (LCAs) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: http://www.cms.gov/medicare-coverage-database/ search.aspx. Additional indications may be covered at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCA/LCD): N/A

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA, LLC
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA, LLC
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC