Neighborhood Health Plan OF RHODE ISLAND™
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Qalsody™ (tofersen)
(Intrathecal)

Effective Date: 01/01/2024
Review Date: 12/14/2023, 01/10/2024
Scope: Medicaid, Commercial, Medicare-Medicaid Plan (MMP)

I. Length of Authorization

Coverage will be provided for 6 months and may be renewed.

II. Dosing Limits

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

- Qalsody 100 mg/15 mL single-dose vial: 1 vial every 14 days x3 doses, then 1 vial every 28 days thereafter

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

- Initial dose: 100 billable units (100 mg) every 14 days, for 3 doses only
- Subsequent doses: 100 billable units (100 mg) every 28 days thereafter

III. Summary of Evidence

Qalsody (tofersen) is indicated for the treatment of adult patients with amyotrophic lateral sclerosis (ALS) who have a mutation in the superoxide dismutase 1 (SOD1) gene (SOD1-ALS). The approval was based on a reduction in plasma neurofilament light (NfL), a biomarker of axonal injury and neurodegeneration that the FDA believes is reasonably likely to predict a clinical benefit in patients with SOD1-ALS. In the Phase 3 VALOR trial, Qalsody failed to demonstrate a statistically significant benefit over placebo on the primary efficacy endpoint, the change from baseline to Week 28 in the Revised Amyotrophic Lateral Sclerosis Functional Rating Scale (ALSFRS-R) in the prespecified analysis population. However, Qalsody did show improvements in multiple secondary and exploratory endpoints. In the overall intent-to-treat population (n = 108), patients who received Qalsody experienced a 55% reduction in plasma NfL compared to a 12% increase in placebo-treated patients (nominal P-value <0.0001). The most common side effects in the clinical trial (≥10% of patients treated with Qalsody and greater than placebo) included pain, fatigue, arthralgia, CSF white blood cell increased, and myalgia.

IV. Initial Approval Criteria [1]

Coverage is provided in the following conditions:

MMP members who have previously received this medication within the past 365 days are not subject to Step Therapy Requirements.

- Patient is at least 18 years of age; **AND**

- Patient has a baseline measure of the plasma neurofilament light chain (NfL); **AND**
- Medication is prescribed by a neurologist, neuromuscular specialist, or physician specializing in the treatment of ALS

Amyotrophic Lateral Sclerosis (ALS) † Φ [1,2,7,8]

- Patient has a diagnosis of clinically definite or probable ALS based on El Escorial revised criteria or Awaji criteria; **AND**
- Patient has the presence of a mutation in the superoxide dismutase 1 *(SOD1)* gene: **AND**
- Patient has a slow vital capacity (%SVC) ≥ 65%; **AND**
- Baseline documentation of retained functionality for most activities of daily living [i.e., score of 2 or better on each***** individual item of the ALS Functional Rating Scale – Revised (ALSFRS-R)]

  ***Note:** the ALSFRS-R is a 12-item questionnaire assessing functional disease progression across four domains including bulbar, fine motor, gross motor, and respiratory. Each item is scored on a five-point ordinal scale from 0 (loss or significant impairment) up to 4 (normal function) with a possible cumulative score of 48. A score of 2 or better on each item would correspond to a minimum ALSFRS-R score of 24.

† FDA-approved indication(s); **‡** Compendium Recommended Indication(s); **Φ** Orphan Drug

V. Renewal Criteria [1,3]

Coverage can be renewed based upon the following criteria:

- Patient continues to meet the indication-specific relevant criteria identified in section III; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: serious myelitis and radiculitis, papilledema and elevated cranial pressure, aseptic meningitis, etc.; **AND**
- Patient has improvement in the plasma neurofilament light chain (NfL) levels compared to baseline; **AND**
- Patient has responded to therapy compared to pretreatment baseline with disease stability or mild progression indicating a slowing of decline on the ALSFRS-R (patient has not experienced rapid disease progression while on therapy); **AND**
- Patient does not have a cumulative score***** on the ALSFRS-R of ≤ 3 (The cumulative possible score on the ALSFRS-R is 48; a cumulative score of 3 indicates loss/significant impairment [i.e., item score of zero] in nine or more items on the 12-item questionnaire)

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VI. Dosage/Administration [1]

Indication	Dose
ALS	Administer 100 mg (15 mL) as 3 loading doses administered at 14-day intervals. A maintenance dose should be administered once every 28 days thereafter.
• Allow to warm to room temperature prior to administration • Administer within 4 hours of removal from vial • Prior to administration, remove approximately 10 mL of cerebrospinal fluid • Administer as an intrathecal bolus injection over 1 to 3 minutes	

VII. Billing Code/Availability Information

HCPCS Code:

- C9157 – Injection, tofersen, 1 mg; 1 billable unit = 1 mg *(Effective 10/01/2023)*
- J1304 – Injection, tofersen, 1 mg *(Effective 01/01/2024)*

NDC:

- 100 mg/15 mL solution in a single-dose glass vial (preservative free): 64406-0109-xx

VIII. References

1. Qalsody [package insert]. Cambridge, MA; Biogen MA, Inc; April 2023. Accessed November 2023.
2. Miller TM, Cudkowicz ME, Genge A, et al; VALOR and OLE Working Group. Trial of Antisense Oligonucleotide Tofersen for SOD1 ALS. N Engl J Med. 2022 Sep 22;387(12):1099-1110. doi: 10.1056/NEJMoa2204705.
3. Cedarbaum JM, Stambler N, Malta E, et al. The ALSFRS-R: a revised ALS functional rating scale that incorporates assessments of respiratory function. BDNF ALS Study Group (Phase III). J Neurol Sci. 1999 Oct 31;169(1-2):13-21.
4. Miller RG, Jackson CE, Kasarskis EJ, et al. Practice parameter update: the care of the patient with amyotrophic lateral sclerosis: drug, nutritional, and respiratory therapies (an evidence-based review): report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology. 2009 Oct 13;73(15):1218-26.
5. Siddique N, Siddique T. Amyotrophic Lateral Sclerosis Overview. GeneReviews. Initial Posting: March 23, 2021; Last Revision: September 30, 2021; Accessed on June 7, 2022. http://www.ncbi.nlm.nih.gov/books/NBK1450/.
6. Hardiman O, van den Berg LH, Kiernan MC. Clinical diagnosis and management of amyotrophic lateral sclerosis. Nat Rev Neurol. 2011 Oct 11;7(11):639-49.

7. Costa J, Swash M, de Carvalho M. Awaji criteria for the diagnosis of amyotrophic lateral sclerosis: a systematic review. Arch Neurol. 2012 Nov;69(11):1410-6.
8. Pinto S, de Carvalho M. SVC Is a Marker of Respiratory Decline Function, Similar to FVC, in Patients With ALS. Front Neurol. 2019 Feb 28;10:109. doi: 10.3389/fneur.2019.00109. PMID: 30873101; PMCID: PMC6403463.

Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
G12.21	Amyotrophic lateral sclerosis

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 Determinations (LCDs), and Local Coverage Articles (LCAs) may exist and compliance with these policies is required where applicable. They can be found at: https://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/LCD/LCA): 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

Policy Rationale:

Qalsody was reviewed by the Neighborhood Health Plan of Rhode Island Pharmacy & Therapeutics (P&T) Committee. Neighborhood adopted the following clinical coverage criteria to ensure that its members use Qalsody according to Food and Drug Administration (FDA) approved labeling and/or relevant clinical literature. Neighborhood worked with network prescribers and pharmacists to draft these criteria. These criteria will help ensure its members are using this drug for a medically accepted indication, while minimizing the risk for adverse effects and ensuring more cost-effective options are used first, if applicable and appropriate. For INTEGRITY (Medicare-Medicaid Plan) members, these coverage criteria will only apply in the absence of National Coverage Determination (NCD) or Local Coverage Determination (LCD) criteria. Neighborhood will give individual consideration to each request it reviews based on the information submitted by the prescriber and other information available to the plan.