Pharmacy Drug Policy & Procedure

Policy Name:	Wainua (eplontersen)	Policy#:	2774P

Purpose of the Policy

The purpose of this policy is to define coverage criteria for Wainua (eplontersen)

Statement of the Policy

Health Alliance Medical Plans will approve the use of Wainua (eplontersen) under the specialty pharmacy benefit if the following criteria are met.

Criteria

1. Coverage Criteria

1.1 Diagnosis of polyneuropathy of hereditary transthyretin-mediated amyloidosis (hATTR-PN)
1.2 Documentation that the patient has a pathogenic TTR gene mutation
1.3 Age 18 years or older
1.4 Presence of clinical signs and symptoms of the disease of polyneuropathy, including peripheral or autonomic, that are determined to be mild to moderate
1.5 Documentation to support all of the following:
- Neuropathy impairment scale score between 10-130
- Stage 1 or 2 familial amyloidotic polyneuropathy (FAP) or Coutinho stage

1.6 Prescribed by or in consultation with a neurologist (nervous system doctor)

2. Exclusion Criteria

2.1 Concurrent coverage with other treatments for hATTR (such as Amvuttra or Onpattro)
2.2 Wainua is not supported to treat hATTR associated cardiomyopathy

3. Managed Dose Limit

3.1 Maximum 0.8 mL per 28 days

4. Approval Period

4.1 Initial: 12 months
4.2 Reauthorization: 12 months with documentation that the patient has experienced a positive clinical response to therapy (e.g., improved neuropathy impairment, motor function, quality of life assessment, serum TTR levels, etc.)

CPT Codes	

HCPCS Codes	

References

1. Wainua (eplontersen) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP: December 2023.
2. Coelho T, Marques W Jr, Dasgupta NR, et al; NEURO-TTRansform Investigators. Eplontersen for Hereditary Transthyretin Amyloidosis With Polyneuropathy. JAMA. 2023 Oct 17;330(15):1448-1458

Created Date: 10/02/24
Effective Date: 10/02/24
Posted to Website: 10/02/24
Revision Date: