Lenmeldy ® (atidarsagene autotemcel)

BENEFIT APPLICATION

Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This medical policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

DESCRIPTION

The intent of the Lenmeldy drug policy is to provide coverage consistent with product labeling, FDA guidance, standards of medical practice, evidence-based drug information, and/or published guidelines. The indications below including FDA-approved indications and compendial uses are considered covered benefits provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

Lenmeldy is indicated for the treatment of children with pre-symptomatic late infantile (PSLI), pre-symptomatic early juvenile (PSEJ) or early symptomatic early juvenile (ESEJ) metachromatic leukodystrophy (MLD).

POLICY

Required Documentation

Submission of the following information is necessary to initiate the prior authorization review:
Chart notes, medical records, or lab results documenting all of the following:

1. PSLI, PSEJ, or ESEJ classification of MLD.
2. Variant(s) in the *ARSA* gene.
3. Deficiency of arylsulfatase A (ARSA) on biochemical testing.
4. Elevated sulfatide levels based on 24-hour urine collection, if applicable.

Prescriber Specialties

The requested medication must be prescribed by or in consultation with a pediatric neurologist with expertise in metachromatic leukodystrophy (MLD).

Criteria for Initial Approval

Metachromatic Leukodystrophy (MLD)

Authorization of 3 months for a one-time administration may be granted for treatment of metachromatic leukodystrophy (MLD) when all of the following criteria are met:

A. Member has a diagnosis of one of the following types of MLD (See Appendix):
   1. Pre-symptomatic late infantile (PSLI)
   2. Pre-symptomatic early juvenile (PSEJ)
   3. Early symptomatic early juvenile (ESEJ)
B. The diagnosis was confirmed by all of the following:
   1. Biochemical testing documenting ARSA activity below the normal range for the laboratory performing the test.
   2. The presence of two disease-causing ARSA alleles, either known or novel mutations, identified on genetic testing.
   3. If novel mutations are identified, a 24-hour urine collection showing elevated sulfatide levels.
C. Member has not previously received Lenmeldy or any other gene therapy
D. Member does not have evidence of residual cells of donor origin if the member has received a prior allogeneic hematopoietic stem cell transplant (allo-HSCT).
E. Member does not have malignant neoplasia (except local skin cancer) or a documented history of hereditary cancer syndrome, myelodysplasia, cytogenic alterations characteristic of myelodysplastic syndrome (MDS) and acute myeloid leukemia (AML), or other serious hematological disorders.
F. Member does not have symptomatic herpes zoster (not responsive to specific treatment) or end-organ dysfunction.
G. Member does not have any active bacterial, fungal, parasitic, or viral infection, including active/uncontrolled HBV and HCV infection.
H. Member is not enrolled in any interventional trials for MLD
I. Member does not have late-juvenile, adult-onset, or other forms of the disease

Continuation of Therapy

Repeat treatment of Lenmeldy for any indication is considered investigational, as the safety and efficacy beyond one dose has not been studied. Approval is limited to one treatment course per lifetime.

Lenmeldy is considered **not medically necessary** for members who do not meet the criteria set forth above.

Dosing and Administration

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia and/or evidence-based practice guidelines. Lenmeldy is recommended for autologous use only as a one-time, single-dose cell suspension for intravenous infusion. Children are required to undergo hematopoietic stem cell (HSC) mobilization followed by apheresis to obtain CD34+ cells for Lenmeldy manufacturing. Myeloablative conditioning must be administered before infusion of Lenmeldy. Dosing of Lenmeldy is based on the number of CD34+ cells in the infusion bag(s) per kg of body weight and the minimum recommended dose is based on the MLD disease subtype.

Minimum and Maximum Recommended Dose of Lenmeldy:

MLD Subtype	Minimum Recommended Dose ($x10^6$ CD34+ cells/kg)	Maximum Recommended Dose ($x10^6$ CD34+ cells/kg)
PSLI	4.2	30
PSEJ	9	

ESEJ	6.6	

Quantity Limits Apply
Lenmeldy approvals will be limited to one treatment per lifetime.

Other Considerations
Vaccinations should not be administered during the 6 weeks preceding the start of myeloablative conditioning, and until hematological recovery following treatment.
(Note: Where feasible, administer childhood vaccinations prior to myeloablative conditioning)

Appendix
MLD classification criteria
PSLI MLD: Children with expected disease onset ≤ 30 months of age and an ARSA genotype consistent with LI MLD. Pre-symptomatic status* defined as the absence of neurological signs and symptoms of MLD.

PSEJ MLD: Children with expected disease onset > 30 months and <7 years of age and an ARSA genotype consistent with EJ MLD. Pre-symptomatic status* defined as the absence of neurological signs and symptoms of MLD or physical exam findings limited to abnormal reflexes and/or clonus.

ESEJ MLD: Children with disease onset > 30 months and <7 years of age and an ARSA genotype consistent with EJ MLD. Early symptomatic status defined as walking independently (GMFC-MLD Level 0 with ataxia or GMFC-MLD Level 1) and IQ ≥ 85.

*Pre-symptomatic children were permitted to have abnormal reflexes or abnormalities on brain magnetic resonance imaging and/or nerve conduction tests not associated with functional impairment (e.g., no tremor, no peripheral ataxia).

PROCEDURES AND BILLING CODES

To report provider services, use appropriate CPT* codes, Alpha Numeric (HCPCS level 2) codes, Revenue codes, and/or ICD diagnostic codes.

- J3391 - Inj, atidarsagene autotemcel (effective 7/1/2025)
- J3490 – Unclassified drugs (when specified as [Lenmeldy] (atidarsagene autotemcel))
- J3590 – Unclassified biologics (when specified as [Lenmeldy] (atidarsagene autotemcel))
- C9399 – Unclassified drugs or biologics (when specified as [Lenmeldy] (atidarsagene autotemcel))

REFERENCES

1. Lenmeldy [package insert]. Boston, MA: Orchard Therapeutics North America.; March 2024.
2. Gomez-Ospina N. Arylsulfatase A Deficiency. 2006 May 30 [Updated 2024 Feb 8]. In: Adam MP, Feldman J, Mirzaa GM, et al., editors. GeneReviews® [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2024. Available from: https://www.ncbi.nlm.nih.gov/books/NBK1130/. Accessed March 19, 2024.
3. Institute for Clinical and Economic Review (ICER). Atidarsagene Autotemcel for Metachromatic Leukodystrophy: Final Policy Recommendations. Available from: https://icer.org/wp-content/uploads/2023/10/MLD-Final-Evidence-Report_For-Publication_10302023.pdf. Published October 30, 2023.

POLICY HISTORY

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