CarePartners of Connecticut MEDICARE ADVANTAGE

Medical Necessity Guidelines
Medical Benefit Drugs

Qalsody™ (tofersen)

Effective: August 1, 2023

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	Yes ☒ No ☐

Applies to:

☒ CarePartners of Connecticut Medicare Advantage HMO plans, Fax 617-673-0956
☒ CarePartners of Connecticut Medicare Advantage PPO plans, Fax 617-673-0956

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Food and Drug Administration (FDA) Approved Indications

Qalsody (tofersen) is an antisense oligonucleotide indicated for the treatment of amyotrophic lateral sclerosis (ALS) in adults who have a mutation in the superoxide dismutase 1 (SOD1) gene.

This indication is approved under accelerated approval based on reduction in plasma neurofilament light chain observed in patients treated with Qalsody (tofersen). Continued approval for this indication may be contingent upon verification of clinical benefit in confirmatory trials.

Clinical Guideline Coverage Criteria

The Plan may authorize coverage of Qalsody for Members when all of the following criteria are met:

1. Documented diagnosis of amyotrophic lateral sclerosis (ALS)

AND

2. Documentation of superoxide dismutase 1 (SOD1) gene mutation

AND

3. Prescribed by or in consultation with a neurologist

Limitations

- None

Codes

The following code(s) require prior authorization:

Table 1: HCPCS Codes

HCPCS Codes	Description
J1304	INJECTION, TOFERSEN, 1 MG

References:

1. Miller RG, 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).
2. Qalsody (tofersen) [package insert]. Cambridge, MA: Biogen MA Inc.; April 2023.

Approval And Revision History

July 11, 2023: Reviewed by the Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

- October 1, 2023: Administrative update: Added new C Code C9157 to Medical Necessity Guideline.
- January 1, 2024: Administrative updated: Added new J Code J1304 to Medical Necessity Guideline and remove C Code C9157.

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.