POLICY Document for VYNDAQEL

The overall objective of this policy is to support the appropriate and cost-effective use of the medication, specific to use of preferred medication options, and overall, clinically appropriate use. This document provides specific information to both sections of the overall policy.

Section 1: Preferred Product
- Policy information specific to preferred medications

Section 2: Clinical Criteria
- Policy information specific to the clinical appropriateness for the medication

Section 1: Preferred Product

CAREFIRST SPECIALTY EXCEPTIONS
TTR Amyloidosis

PREFERRED PRODUCTS: ONPATTRO, AMVUTTRA

POLICY
This policy informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

I. PLAN DESIGN SUMMARY

This program applies to the products for the treatment of transthyretin-mediated amyloidosis specified in this policy. Coverage for the targeted product is provided based on clinical circumstances that would exclude the use of the preferred product and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to all members who are requesting treatment with the targeted products

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table. TTR Amyloidosis Products

	Product(s)
Preferred*	• **Amvuttra** (vutrisiran) • **Onpattro** (patisiran)
Targeted	• **Attruby** (acoramidis) • **Tegsedi** (inotersen) • **Vyndamax** (tafamidis) • **Vyndaqel** (tafamidis meglumine) • **Wainua** (eplontersen)

*: Medications considered formulary or preferred on your plan may still require a clinical prior authorization review.

II. EXCEPTION CRITERIA

This program applies to members requesting treatment for an indication that is FDA-approved for the preferred product.

Coverage for Vyndamax, Vyndaqel, or Attruby is provided when the member is using concomitantly with Amvuttra for cardiomyopathy associated with wild-type or hereditary transthyretin-mediated amyloidosis.

Coverage for all other targeted products is provided when member has a documented inadequate response, contraindication, or intolerable adverse event to all preferred products.

Section 2: Clinical Criteria

Specialty Guideline Management Vyndaqel-Vyndamax

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Vyndaqel	tafamidis meglumine
Vyndamax	tafamidis

Indications

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-approved Indication[1]

Vyndaqel and Vyndamax are transthyretin stabilizers indicated for the treatment of the cardiomyopathy of wild-type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) in adults to reduce cardiovascular mortality and cardiovascular-related hospitalization.

All other indications are considered experimental/investigational and not medically necessary.

Documentation

Submission of the following information is necessary to initiate the prior authorization review:

Initial requests

Chart notes or medical record documentation of prior hospitalization of heart failure or confirming the member demonstrates clinical symptoms of heart failure at baseline.

For biopsy proven disease:

- Tissue biopsy from cardiac or noncardiac sites confirming the presence of the transthyretin amyloid deposition.
- Immunohistochemical analysis, mass spectrometry, tissue staining, or polarized light microscopy results confirming the presence transthyretin precursor proteins.

For technetium-labeled bone scintigraphy proven disease:

- Scintigraphy tracing results confirming the presence of amyloid deposits.
- Serum kappa/lambda free light chain ratio, serum protein immunofixation, and urine protein immunofixation test results showing the absence of monoclonal proteins.

For hereditary ATTR-CM: testing or analysis confirming a pathogenic or likely pathogenic variant in the transthyretin (TTR) gene.

Continuation requests

Chart notes or medical record documentation confirming the member demonstrates a beneficial response to treatment (e.g., improvement in rate of disease progression as demonstrated by distance walked on the 6-minute walk test, the Kansas City Cardiomyopathy Questionnaire–Overall Summary [KCCQ-OS] score, cardiovascular-related hospitalizations, New York Heart Association [NYHA] classification of heart failure, left ventricular stroke volume, N-terminal B-type natriuretic peptide [NT-proBNP] level).

Prescriber Specialties

This medication must be prescribed by or in consultation with a geneticist, cardiologist, or a physician specializing in the treatment of amyloidosis.

Coverage Criteria

Cardiomyopathy of wild-type or hereditary transthyretin-mediated amyloidosis (ATTR-CM)[1-6]

Authorization of 12 months may be granted for treatment of cardiomyopathy of wild-type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) when all of the following criteria are met:

Member is 18 years of age or older.
Member has medical history of heart failure with at least one prior hospitalization for heart failure (not due to arrhythmia or a conduction system disturbance treated with a permanent pacemaker), OR exhibits clinical symptoms of heart failure (e.g., volume overload, dyspnea, fatigue, orthostatic hypotension, syncope, peripheral edema) at baseline.
Diagnosis is confirmed by either of the following criteria:

- Member meets both of the following criteria for biopsy proven disease:

  Presence of transthyretin amyloid deposits on analysis of biopsy from cardiac or noncardiac sites.

  Presence of transthyretin precursor proteins was confirmed by immunohistochemical analysis, mass spectrometry, tissue staining, or polarized light microscopy.
- Member meets both of the following criteria for technetium-labeled bone scintigraphy proven disease:

  Presence of amyloid deposits confirmed by technetium-labeled bone scintigraphy tracing.

  Systemic light chain amyloidosis is ruled out by showing the absence of monoclonal proteins by all of the following tests: a) serum kappa/lambda free light chain ratio, b) serum protein immunofixation, and c) urine protein immunofixation.

For members with hereditary ATTR-CM, the diagnosis is confirmed by detection of a pathogenic or likely pathogenic variant in the TTR gene.
Member does not have either of the following:

- A history of liver or heart transplant
- Implantation of left-ventricular assist device

The requested medication will not be used in combination with inotersen (Tegsedi), patisiran (Onpattro), vutrisiran (Amvuttra), eplontersen (Wainua), or acoramidis (Attruby).

Continuation of Therapy

Authorization of 12 months may be granted for continued treatment of ATTR-CM when both of the following criteria are met:

Member must meet all requirements in the coverage criteria.
Member must have demonstrated a beneficial response to treatment with tafamidis therapy (e.g., improvement in rate of disease progression as demonstrated by distance walked on the 6-minute walk test, the Kansas City Cardiomyopathy Questionnaire–Overall Summary [KCCQ-OS] score, cardiovascular-related hospitalizations, NYHA classification of heart failure, left ventricular stroke volume, N-terminal B-type natriuretic peptide [NT-proBNP] level).

REFERENCES:

SECTION 1

1. Amvuttra [package insert]. Cambridge, MA: Alnylam Pharmaceuticals, Inc.; March 2025.
2. Onpattro [package insert]. Cambridge, MA: Alnylam Pharmaceuticals, Inc.; January 2024.

3. Tegsedi [package insert]. Waltham, MA: Sobi Inc; January 2024.
4. Vyndaqel and Vyndamax [package insert]. New York, NY: Pfizer Labs; October 2023.
5. Wainua [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP: April 2025.

SECTION 2

1. Vyndaqel and Vyndamax [package insert]. New York, NY: Pfizer Labs; October 2023.
2. Maurer MS, Schwartz JH, Gundapaneni B, et al. Tafamidis treatment for patients with transthyretin amyloid cardiomyopathy. N Engl J Med. 2018;379(11):1007-1016.
3. Maurer MS, Sabahat B, Thibaud D, et al. Expert consensus recommendations for the suspicion and diagnosis of transthyretin cardiac amyloidosis. Circ Heart Fail. 2019;12(9):e006075.
4. Kittleson MM, Maurer MS, Ambardekar AV, et al. Cardiac amyloidosis: Evolving diagnosis and management: A scientific statement from the American Heart Association. Circulation. 2020;142(1):e7-e22.
5. Yadav JD, Othee H, Chan KA, et al. Transthyretin amyloid cardiomyopathy-Current and future therapies. Ann Pharmacother. 2021;55(12):1502-1514.
6. Kittleson MM, Ruberg FL, Ambardekar AV, et al. 2023 ACC expert consensus decision pathway on comprehensive multidisciplinary care for the patient with cardiac amyloidosis: A report of the American College of Cardiology solution set oversight committee. 2023;88(11):1076-1126.