Reference number(s)
7654-A

Specialty Guideline Management
Isembyld

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
Isembyld	apitegromab-mstn

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 Indications[1]

Isembyld is indicated for the treatment of spinal muscular atrophy (SMA) in adults and pediatric patients 2 years of age and older who are currently receiving a survival motor neuron 2 (SMN2)-targeted treatment.

All other indications are considered experimental and not medically necessary.

Documentation

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

Initial Requests:

- Deletion or mutation at the SMN1 allele confirmed by genetic testing.
- Medical records (e.g., chart notes, laboratory values) of the baseline assessment for the Hammersmith Functional Motor Scale Expanded (HFMSE).

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Continuation Requests:

- Medical records (e.g., chart notes, medical records, laboratory values) documenting either of the following:
  - The most recent (less than 1 month prior to continuation request) Hammersmith Functional Motor Scale Expanded (HFMSE) assessment.
  - Achievement or maintenance of any new motor milestone or improvement in clinical status from pretreatment baseline.
- For members prescribed Isembyld due to clinical worsening after receiving gene replacement therapy (e.g., Zolgensma, Itvisma): documentation of the impact of therapy (e.g., impact on motor milestones).

Prescriber Specialties

This medication must be prescribed by or in consultation with a physician who specializes in treatment of spinal muscular atrophy.

Coverage Criteria[1-4]

Spinal Muscular Atrophy (SMA)

Authorization of 12 months may be granted for treatment of SMA when all of the following criteria are met:

- Member is between 2 and 22 years of age.
- Member has type 2 or type 3 SMA.
- There is genetic documentation of 5q SMA homozygous gene mutation, homozygous gene deletion, or compound heterozygote.
- Member is able to sit independently at baseline (sits up straight with head erect for at least 10 seconds; does not use arms or hands to balance body or support position).
- Member's baseline score for the Hammersmith Functional Motor Scale Expanded (HFMSE) is ≥10 and ≤45.
- Member is not dependent on either of the following:
  - Invasive ventilation or tracheostomy
  - Use of non-invasive ventilation beyond naps and nighttime sleep
- Member meets one of the following criteria:
  - Member has not previously received gene replacement therapy for SMA (e.g., Zolgensma, Itvisma), or
  - Member has previously received gene replacement therapy for SMA (e.g., Zolgensma, Itvisma) and has experienced a worsening in clinical status since receiving gene replacement therapy as demonstrated by a decline of at least 3 points from the highest score achieved on the HFMSE.

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- The requested medication will be used in combination with Evrysdi or Spinraza.

Continuation of Therapy[1-4]

Note: Members who were previously established on Isembyld and subsequently administered gene replacement therapy (e.g., Zolgensma, Itvisma) must meet all requirements in the coverage criteria section prior to re-starting therapy on Isembyld.

Authorization of 12 months may be granted for continued treatment of SMA when all of the following criteria are met:

- Member has type 2 or type 3 SMA.
- Member is not dependent on either of the following:
  - Invasive ventilation or tracheostomy
  - Use of non-invasive ventilation beyond naps and nighttime sleep
- Member is able to sit independently (sits up straight with head erect for at least 10 seconds; does not use arms or hands to balance body or support position).
- Member demonstrates a clinically positive response to therapy, which shall include improvement, stabilization, or slowing of disease progression, by either of the following:
  - Improvement or stabilization in the most recent (less than 1 month prior to continuation request) Hammersmith Functional Motor Scale Expanded (HFMSE) score from pretreatment baseline.
  - Member has achieved or maintained any new motor milestone or improvement in clinical status from pretreatment baseline when they would otherwise be unexpected to do so.
- If the member was prescribed Isembyld due to clinical worsening after receiving gene replacement therapy (e.g., Zolgensma, Itvisma), there is documentation of stabilization or improvement in clinical status with therapy (e.g., impact on motor milestones).
- The requested medication will be used in combination with Evrysdi or Spinraza.

References

1. Isembyld [package insert]. Cambridge, MA: Scholar Rock, Inc.; September 2026.
2. Crawford TO, Servais L, Mercuri E, et al. Safety and efficacy of apitegromab in nonambulatory type 2 or type 3 spinal muscular atrophy (SAPPHIRE): a phase 3, double-blind, randomised, placebo-controlled trial. Lancet Neurol. 2025;24(9):727-739. doi:10.1016/S1474-4422(25)00225-X.
3. Pierzchlewicz K, Kępa I, Podogrodzki J, Kotulska K. Spinal Muscular Atrophy: The Use of Functional Motor Scales in the Era of Disease-Modifying Treatment. Child Neurol Open. 2021;8:2329048X211008725. Published 2021 Apr 27. doi:10.1177/2329048X211008725
4. Arnold WD, Kassar D, Kissel JT, et al. Spinal muscular atrophy: diagnosis and management in a new therapeutic era. Muscle & Nerve. 2015;51(2):157-167.

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