Voretigene neparvovec-rzyl adeno-associated virus vector-based gene therapy subretinal injection is considered **MEDICALLY NECESSARY** for patients with vision loss due to biallelic *RPE65* pathogenic variant-associated retinal dystrophy if they meet all of the following criteria:

- **Are adults (age <65 years) or children (age ≥3 years)**
- **Documentation of the following:**
  - Genetic testing confirming presence of bilallelic RPE65 pathogenic variant(s)*
    - Single RPE65 pathogenic variant found in the homozygous state
    - Two RPE65 pathogenic variants found in the trans configuration (compound heterozygous state) by segregation analysis
  - Presence of viable retinal cells as determined by treating physicians as assessed by optical coherence tomography imaging and/or ophthalmoscopy:
    - An area of retina within the posterior pole of >100 μm thickness shown on optical coherence tomography, OR
    - ≥3 disc areas of retina without atrophy or pigmentary degeneration within the posterior pole, OR
- Any remaining visual field within 30° of fixation as measured by III4e/V4e isopter equivalent, OR
- Measureable full-field light sensitivity threshold (FST).

- Do not have any of the following:
  - Pregnancy in females.
  - Breastfeeding.
  - Use of prescription retinoid compounds or precursors that could potentially interact with the biochemical activity of the RPE65 enzyme; individuals who discontinue use of these compounds for 3 months may become eligible.
  - Prior intraocular surgery within 3 months.
  - Preexisting eye conditions or complicating systemic diseases that would eventually lead to irreversible vision loss and prevent the patient from receiving full benefit from Voretigene neparov-czyl (eg, leukemia with central nervous system/optic nerve involvement, severe diabetic retinopathy).
  - Patients with immunodeficiency (acquired or congenital) because they could be susceptible to opportunistic infection (eg, cytomegalovirus retinitis).

*Diagnosis of Biallelic RPE65-Mediated Inherited Retinal Dystrophies*

Genetic testing is required to detect the presence of pathogenic(s) variants in the RPE65 gene. By definition, pathogenic variant(s) must be present in both copies of the RPE65 gene to establish a diagnosis of biallelic RPE65-mediated inherited retinal dystrophy.

A single RPE65 pathogenic variant found in the homozygous state (eg, the presence of the same pathogenic variant in both copies alleles of the RPE65 gene) establishes a diagnosis of biallelic RPE65-mediated dystrophinopathy.

However, if 2 different RPE65 pathogenic variants are detected (eg, compound heterozygous state), confirmatory testing such as segregation analysis by family studies may be required to determine the trans vs cis configuration (eg, whether the 2 different pathogenic variants are found in different copies or in the same copy of the RPE65 gene). The presence of 2 different RPE65 pathogenic variants in separate copies of the RPE65 gene (trans configuration) establishes a diagnosis of biallelic RPE65-mediated dystrophinopathy. The presence of 2 different RPE65 pathogenic variants in only 1 copy of the RPE65 gene (cis configuration) is not considered a biallelic RPE65-mediated dystrophinopathy.

Next-generation sequencing and Sanger sequencing typically cannot resolve the phase (eg, trans vs cis configuration) when two RPE65 pathogenic variants are detected. In this scenario, additional documentation of the trans configuration is required to establish a diagnosis of biallelic RPE65-mediated inherited retinal dystrophy. Table PG1 provides a visual representation of the genetic status requirements to establish a diagnosis of RPE65-mediated inherited retinal dystrophy.

**Table PG1. Genetic Diagnosis of RPE65-Mediated Inherited Retinal Dystrophy**

<table>
<thead>
<tr>
<th>Genetic Status</th>
<th>Diagram</th>
<th>Diagnosis of RPE65-Mediated Inherited Retinal Dystrophy?</th>
</tr>
</thead>
</table>
| Homozygous     | RPE65 gene copy #1 (- - - - X - - - -)  
RPE65 gene copy #2 (- - - - X - - - -)  
X=single RPE65 pathogenic variant | Yes |
| Heterozygous (trans configuration) | RPE65 gene copy #1 (- - - - X - - - -)  
RPE65 gene copy #2 (- - O - - - - - -)  
X=RPE65 pathogenic variant #1  
O=RPE65 pathogenic variant #2 | Yes |
| Heterozygous (cis configuration) | RPE65 gene copy #1 (- - O - - X - - - -)  
RPE65 gene copy #2 (- - - - - - - -) | No |
Other applications of voretigene neparvovec-rzyl are considered **INVESTIGATIONAL**.

### Prior Authorization Information
Pre-service approval is required for all inpatient services for all products. See below for situations where prior authorization may be required or may not be required. Yes indicates that prior authorization is required. No indicates that prior authorization is not required. N/A indicates that this service is primarily performed in an inpatient setting.

<table>
<thead>
<tr>
<th>Outpatient Service</th>
<th>Commercial Managed Care (HMO and POS)</th>
<th>Yes*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Commercial PPO and Indemnity</td>
<td>Yes*</td>
</tr>
<tr>
<td></td>
<td>Medicare HMO BlueSM</td>
<td>Yes*</td>
</tr>
<tr>
<td></td>
<td>Medicare PPO BlueSM</td>
<td>Yes*</td>
</tr>
</tbody>
</table>

*Preauthorization Request Form: Gene Therapy for Inherited Retinal Dystrophy
This form must be completed and faxed to: Medical and Surgical: 1-888-282-0780; Medicare Advantage: 1-800-447-2994.
Click here for [Gene Therapy for Inherited Retinal Dystrophy Preauthorization Request Form, #926](#).

### CPT Codes / HCPCS Codes / ICD Codes
Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

<table>
<thead>
<tr>
<th>HCPCS codes</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9399</td>
<td>Unclassified drugs or biological</td>
</tr>
<tr>
<td>J3490</td>
<td>Unclassified drugs</td>
</tr>
<tr>
<td>J3590</td>
<td>Unclassified biologics</td>
</tr>
</tbody>
</table>

### Description
**INHERITED RETINAL DYSTROPHIES**
Inherited retinal dystrophies are a diverse group of disorders with overlapping phenotypes characterized by progressive degeneration and dysfunction of the retina. The most common subgroup is retinitis pigmentosa, which is characterized by a loss of retinal photoreceptors, both cones and rods. The hallmark of the condition is night blindness (nyctalopia) and loss of peripheral vision. These losses lead to difficulties in performing visually dependent activities of daily living such as orientation and navigation in dimly lit areas. Visual acuity may be maintained longer than peripheral vision, though eventually, most individuals progress to vision loss.
**RPE65 Gene**
Retinitis pigmentosa (RP) and Leber congenital amaurosis (LCA) both have subtypes related to pathogenic variants in *RPE65*. *RPE65* (retinal pigment epithelium-specific protein 65-kD) gene encodes the RPE65 protein, an all-trans retinal isomerase, a key enzyme expressed in the retinal pigment epithelium (RPE) that is responsible for regeneration of 11-cis-retinol in the visual cycle. The *RPE65* gene is located on the short (p) arm of chromosome 1 at position 31.3 (1p31.3). Individuals with biallelic variations in *RPE65* lack the RPE65 enzyme; this lack leads to build-up of toxic precursors and damage to RPE cells, loss of photoreceptors, and eventually complete blindness.

**Epidemiology**
*RPE65*-associated inherited retinal dystrophy is rare. The prevalence of LCA has been estimated to be between 1 in 33,000 and 1 in 81,000 individuals in the United States. LCA subtype 2 (RPE65-associated LCA) accounts for between 5% and 16% of cases of LCA. The prevalence of RP in the United States is approximately 1 in 3500 to 1 in 4000 with approximately 1% of patients with RP having *RPE65* variants. Assuming a U.S. population of approximately 326.4 million at the end of 2017, the prevalence of *RPE65*-associated inherited retinal dystrophies in the United States would, therefore, be roughly 1000 to 2500 individuals. Table 1 summarizes the estimated pooled prevalence of *RPE*-associated inherited retinal dystrophy and the range of estimated cases based on the estimated 2017 U.S. population.

<table>
<thead>
<tr>
<th>Description</th>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated pooled prevalence of RPE65-mediated inherited retinal dystrophies (eg, LCA type 2, RPE65-mediated RP)</td>
<td>1:330,000</td>
<td>1:130,000</td>
</tr>
<tr>
<td>Estimated number of patients</td>
<td>1000</td>
<td>2500</td>
</tr>
</tbody>
</table>

LCA type 2: Leber congenital amaurosis type 2; RP: retinitis pigmentosa.

**GENE THERAPY**
Gene therapies are treatments that change the expression of genes to treat disease, eg, by replacing or inactivating a gene that is not functioning properly or by introducing a new gene. Genes may be introduced into human cells through a vector, usually a virus. Adeno-associated viruses (AAV) are frequently used due to their unique biology and simple structure. These viruses are in the parvovirus family and are dependent on coinfection with other viruses, usually adenoviruses, to replicate. AAVs are poorly immunogenic compared with other viruses but can still trigger immune response making it a challenge to deliver an effective dose without triggering an immune response that might render the gene therapy ineffective or harm the patient. There are over 100 different AAVs, and 12 serotypes have been identified so far, labeled AAV1 to AAV12; in particular, AAV2, AAV4, and AAV5 are specific for retinal tissues. The recombinant AAV2 is the most commonly used AAV serotype in gene therapy.

The eye is a particularly appropriate target for gene therapy due to the immune privilege provided by the blood-ocular barrier and the minimal amount of vector needed, given the size of the organ. Gene therapy for *RPE65* variant-associated retinal dystrophy using various AAV vectors to transfect cells with a functioning copy of *RPE65* in the RPE cells has been investigated.

**Summary**
Inherited retinal dystrophy can be caused by recessive variants in the RPE65 gene. Patients with biallelic variants have difficulty seeing in dim light and progressive loss of vision. These disorders are rare and have traditionally been considered untreatable. Gene therapy with an adeno-associated virus vector expressing RPE65 has been proposed as a treatment to improve visual function.

For individuals who have vision loss due to biallelic RPE65 variant-associated retinal dystrophy who receive gene therapy, the evidence includes randomized controlled trials and uncontrolled trials. Relevant outcomes are symptoms, morbid events, functional outcomes, quality of life, and treatment-related
morbidity. Biallelic RPE65 variant-associated retinal dystrophy is a rare condition and, as such, it is recognized that there will be particular challenges in generating evidence, including recruitment for adequately powered randomized controlled trials, validation of novel outcome measures, and obtaining long-term data on safety and durability. There are no other Food and Drug Administration-approved pharmacologic treatments for this condition. One randomized controlled trial (N=31) comparing voretigene neparvovec with a control demonstrated greater improvements on the Multi-Luminance Mobility Test, which measures the ability to navigate in dim lighting conditions. Most other measures of visual function were also significantly improved in the voretigene neparvovec group compared with the control group. Adverse events were mostly mild to moderate. However, there is limited follow-up available. Therefore, the long-term efficacy and safety are unknown. Based on a small number of patients from early phase studies, voretigene neparvovec appears to have durable effects to at least 3 years. Other gene therapies tested in early phase trials have shown improvements in retinal function but variable durability of effect; some patients from 2 cohorts who initially experienced improvements have subsequently experienced declines after 1 to 3 years. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
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</table>

Information Pertaining to All Blue Cross Blue Shield Medical Policies
Click on any of the following terms to access the relevant information:

- Medical Policy Terms of Use
- Managed Care Guidelines
- Indemnity/PPO Guidelines
- Clinical Exception Process
- Medical Technology Assessment Guidelines

References


