Corporate Medical Policy: Atidarsagene autotemcel (Lenmeldy®) **"Notification"** **POLICY EFFECTIVE APRIL 1, 2026**

Restricted Product(s):

- atidarsagene autotemcel (Lenmeldy®) intravenous infusion for administration by a healthcare professional

FDA Approved Use:

- 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)

Criteria for Medical Necessity:

The restricted product(s) may be considered medically necessary when the following criteria are met:

1. The patient is less than 18 years of age; **AND**
2. The patient has a diagnosis of **metachromatic leukodystrophy (MLD)**, also known as arylsulfatase A deficiency **[medical record documentation required]**; **AND**
3. The diagnosis has been confirmed by the following biochemical and molecular markers:
    a. Arylsulfatase A (ARSA) enzyme activity below the normal range in peripheral blood mononuclear cells-leukocytes or fibroblasts **[medical record documentation required]**; **AND**
    b. Presence of biallelic *ARSA* pathogenic mutations of either known or novel polymorphisms **[medical record documentation required]**; **AND**
        i. If novel *ARSA* variant(s) are present, the patient has had a 24-hour urine collection showing elevated sulfatide levels **[medical record documentation required]**; **AND**
4. ONE of the following:
    a. The patient has pre-symptomatic late infantile (PSLI) subtype of MLD, as defined by:
        i. Expected disease onset less than or equal to 30 months of age **[medical record documentation required]**; **AND**
        ii. An *ARSA* genotype consistent with late infantile MLD (i.e., two null [0] mutant *ARSA* alleles) **[medical record documentation required]**; **AND**
        iii. Absence of neurological signs and symptoms of MLD associated with functional impairment (e.g., no tremor, no peripheral ataxia) **[medical record documentation required]**; **OR**
    b. The patient has pre-symptomatic early juvenile (PSEJ) subtype of MLD, as defined by:
        i. Expected disease onset between 30 months and 7 years of age (i.e., has not celebrated their 7th birthday) **[medical record documentation required]**; **AND**

   ii. An *ARSA* genotype consistent with early juvenile MLD (i.e., one null [0] and one residual [R] mutant *ARSA* allele[s]) **[medical record documentation required]**; **AND**
   iii. Absence of neurological signs and symptoms of MLD associated with functional impairment (e.g., no tremor, no peripheral ataxia) or physical examination findings limited to abnormal reflexes and/or clonus **[medical record documentation required]**; **OR**

c. The patient has early symptomatic early juvenile (ESEJ) subtype of MLD, as defined by:
   i. Disease onset between 30 months and 7 years of age (i.e., has not celebrated their 7th birthday) **[medical record documentation required]**; **AND**
   ii. An *ARSA* genotype consistent with early juvenile MLD (i.e., one null [0] and one residual [R] mutant *ARSA* allele[s]) **[medical record documentation required]**; **AND**
   iii. BOTH of the following **[medical record documentation required]**:
      1. Walking independently (i.e., Gross Motor Function Classification [GMFC]-MLD score of 0 with ataxia or score of 1 with or without ataxia); **AND**
      2. Normal cognitive function (i.e., IQ greater than or equal to 85 on age-appropriate neurocognitive testing); **AND**

5. The patient does NOT have late juvenile- or adult-onset subtype of MLD **[medical record documentation required]**; **AND**
6. The patient is a candidate for autologous stem cell transplantation (e.g., adequate renal and hepatic function) **[medical record documentation required]**; **AND**
7. The patient has been screened and found to be negative for hepatitis B virus (HBV), hepatitis C virus (HCV), human T-lymphotrophic virus 1 & 2 (HTLV-1/HTLV-2), human immunodeficiency virus 1 & 2 (HIV-1/HIV-2), and mycoplasma infection before collection of cells for manufacturing **[medical record documentation required]**; **AND**
8. The patient will NOT receive vaccinations during the 6 weeks preceding the start of myeloablative conditioning, and until hematological recovery following treatment with the requested agent **[medical record documentation required]**; **AND**
9. The patient has NOT undergone prior allogeneic hematopoietic stem cell transplantation nor has evidence of residual cells of donor origin **[medical record documentation required]**; **AND**
10. The patient has NOT had any previous gene therapy, including the requested agent **[medical record documentation required]**; **AND**
11. The prescriber is a specialist in the area of the patient's diagnosis (e.g., pediatric neurologist, hematologist, specialist in the treatment of MLD) or has consulted with a specialist in the area of the patient's diagnosis **[medical record documentation required]**; **AND**
12. The requested dose is within FDA labeled dosing for the requested indication, and the requested quantity does NOT exceed the maximum units allowed for the duration of approval (see table below) **[medical record documentation required]**.

Duration of Approval: 180 days (one treatment course per lifetime)

Please note, for certain identified gene and cellular therapies such as atidarsagene autotemcel (Lenmeldy®), when coverage is available and the individual meets medically necessary criteria, distribution from a specialty pharmacy provider due to cost (distribution channel restriction) may be required in order for coverage to be provided. **Please contact Blue Cross NC to coordinate this therapy.

FDA Label Reference				
Medication	**Indication**	**Dosing**	**HCPCS**	**Maximum Units***
atidarsagene autotemcel (Lenmeldy®) intravenous (IV) infusion	Pre-symptomatic late infantile (PSLI), pre-symptomatic early juvenile (PSEJ) or early symptomatic early juvenile (ESEJ) metachromatic leukodystrophy (MLD) in children	Given IV as a one-time single-dose infusion. Maximum recommended dose is 30 x 10^6 $CD34^+$ cells/kg. Minimum recommended dose is based on the MLD disease subtype: • Pre-symptomatic late infantile: 4.2 x 10^6 $CD34^+$ cells/kg • Pre-symptomatic early juvenile: 9 x 10^6 $CD34^+$ cells/kg • Early symptomatic early juvenile: 6.6 x 10^6 $CD34^+$ cells/kg	J3391	**1**

***Maximum units allowed for duration of approval**

Other revenue codes that may be applicable to this policy: 0891, 0892

References: all information referenced is from FDA package insert unless otherwise noted below.

1. Fumagalli F, Calbi V, Natali Sora MG, et al. Lentiviral haematopoietic stem-cell gene therapy for early-onset metachromatic leukodystrophy: long-term results from a non-randomised, open-label, phase 1/2 trial and expanded access. *Lancet*. 2022;399(10322):372-383.
2. Sessa M, Lorioli L, Fumagalli F, et al. Lentiviral haemopoietic stem-cell gene therapy in early-onset metachromatic leukodystrophy: an ad-hoc analysis of a non-randomised, open-label, phase 1/2 trial. *Lancet*. 2016;388(10043):476-487.

Policy Implementation/Update Information: Criteria and treatment protocols are reviewed annually by the Blue Cross NC P&T Committee, regardless of change. This policy is reviewed in Q2 annually.

April 2026: Coding change: Added the following applicable revenue codes associated with policy HCPCS code(s): 0891 (Special Processed Drugs – FDA Approved Cell Therapy) and 0892 (Special Processed Drugs – FDA Approved Gene Therapy). **Policy notification given 2/1/2026 for effective date 4/1/2026**.
October 2025: Criteria change: For PSLI MLD and PSEJ MLD disease subtypes, adjusted absence of symptoms wording to specify neurologic symptoms not associated with functional impairment.
July 2025: Coding change: Added HCPCS code J3391 to dosing reference table effective 7/1/2025; deleted C9399, J3490, and J3590 termed 6/30/2025.
July 2024: Original medical policy criteria issued.