Clinical Policy: Elamipretide (Forzinity)

Reference Number: CP.PHAR.680
Effective Date: 09.19.25
Last Review Date: 12.25
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Elamipretide (Forzinity™) is a mitochondrial-targeting agent peptide that binds to cardiolipin.

FDA Approved Indication(s)

Forzinity is indicated to improve muscle strength in adult and pediatric patients with Barth syndrome weighing at least 30 kg.*

*This indication is approved under accelerated approval based on an improvement in knee extensor muscle strength, an intermediate clinical endpoint. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results, or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Forzinity is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Barth Syndrome (must meet all)**:**

1. Diagnosis of Barth syndrome confirmed by DNA testing for the presence of a mutation in the tafazzin (TAZ) gene;
2. Prescribed by or in consultation with a clinical geneticist, metabolic disease specialist, endocrinologist, cardiologist, hematologist, or neurologist;
3. Weight ≥ 30 kg;
4. Documentation of impaired muscle strength (e.g., knee extensor muscle strength measured by handheld dynamometry);
5. Dose does not exceed both of the following (a and b):
   a. 40 mg per day;
   b. 1 vial per 7 days.

Approval duration: 6 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business:

CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or

b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Barth Syndrome (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B)*;
2. Member is responding positively to therapy as evidenced by improvement in muscle strength; (e.g. knee extensor muscle strength measured by handheld dynamometry);.
3. If request is for a dose increase, new dose does not exceed both of the following (a and b):
   a. 40 mg per day;
   b. 1 vial per 7 days.

Approval duration:
Medicaid/HIM – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line

of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
TAZ: tafazzin gene

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings
- Contraindication(s): serious hypersensitivity to any of the ingredients
- Boxed warning(s): none reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Barth syndrome	40 mg SC QD	40 mg/day

VI. Product Availability

Vial: 280 mg/3.5 mL (80 mg/mL)

VII. References

1. Forzinity Prescribing Information. Needham, MA: Stealth BioTherapeutics Inc. September 2025. Available at https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/215244s000lbl.pdf. Accessed October 6, 2025.
2. Thompson WR, Manuel R, Abbruscato A, et al. Long-term efficacy and safety of elamipretide in patients with Barth syndrome: 168-week open-label extension results of TAZPOWER. Genet Med. 2024 Jul;26(7):101138. doi: 10.1016/j.gim.2024.101138.
3. Reid Thompson W, Hornby B, Manuel R, et al. A phase 2/3 randomized clinical trial followed by an open-label extension to evaluate the effectiveness of elamipretide in Barth syndrome, a genetic disorder of mitochondrial cardiolipin metabolism. *Genet Med*. 2021 Mar;23(3):471-478. doi: 10.1038/s41436-020-01006-8.
4. Clarke SL, Bowron A, Gonzalez IL, et al. Barth syndrome. *Orphanet journal of rare diseases*. 2013 Feb 12;8(1):1. doi: 10.1186/1750-1172-8-23
5. Van Werkhoven MA, Thorburn DR, et al. Monolysocardiolipin in cultured fibroblasts is a sensitive and specific marker for Barth Syndrome. *J Lipid Res.* 2006 Oct;47(10):2346-51. doi: 10.1194/jlr.D600024-JLR200.

6. Kulik W, van Lenthe H, Stet FS, et al. Bloodspot assay using HPLC-tandem mass spectrometry for detection of Barth syndrome. *Clin Chem*. 2008 Feb;54(2):371-8. doi: 10.1373/clinchem.2007.095711.
7. Vaz FM, van Lenthe H, Vervaart MAT, et al. An improved functional assay in blood spot to diagnose Barth syndrome using the monolysocardiolipin/cardiolipin ratio. *J Inherit Metab Dis*. 2022 Jan;45(1):29-37. doi: 10.1002/jimd.12425.

Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
C9399	Unclassified drugs or biologicals
J3490	Unclassified drugs

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created pre-emptively	05.07.24	08.24
3Q 2025 annual review: no significant changes as the drug is not yet FDA-approved; references reviewed and updated.	05.06.25	08.25
Drug is now FDA approved - criteria updated per FDA labeling; added weight requirement; added requirement for documentation of impaired muscle strength; added quantity limit of 1 vial per 7 days; in continued therapy, specified positive response to therapy as improvement in muscle strength; references reviewed and updated.	11.04.25	12.25

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and

limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.