Preemptive policy: This is a P&T approved policy and can be used after the drug is FDA approved until it is superseded by an updated policy

CENTENE® Corporation

Clinical Policy: Clemidsogene Lanparvovec (RGX-121)

Reference Number: CP.PHAR.734
Effective Date: FDA Approval Date
Last Review Date: 08.26
Line of Business: Commercial, HIM/ICHRA, Medicaid

Coding Implications
Revision Log

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

Description

Clemidsogene lanparvovec (RGX-121®/™) is adeno-associated virus (AAV) vector-based gene therapy.

FDA Approved Indication(s) [Pending]

RGX-121 is indicated for the treatment of mucopolysaccharidosis type II (MPS II; Hunter syndrome).

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.

All requests reviewed under this policy require **Precision Drug Action Committee (PDAC) Utilization Management Review**. Refer to CC.PHAR.21 for process details.

It is the policy of health plans affiliated with Centene Corporation® that RGX-121 is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria*

**Criteria will mirror the clinical information from the prescribing information once FDA-approved*

A. Mucopolysaccharidosis II: Hunter Syndrome (must meet all)**:**

1. Diagnosis of MPS II (Hunter syndrome) confirmed by both of the following (a and b):*
   a. Genetic confirmation of pathogenic or likely pathogenic mutation(s) in the iduronate-2-sulfatase (*IDS)* gene;
   b. Enzyme assay demonstrating a deficiency of *IDS* activity;
2. Prescribed by or in consultation with a specialist with expertise in lysosomal storage diseases (e.g., medical geneticist, pediatric endocrinologist) or a neurologist;*
3. Age ≥ 4 months to ≤ 5 years;*
4. Member has or is expected to have a neuronopathic form of MPS II as evidenced by one of the following (a, b, or c):*
   a. Neurocognitive testing demonstrating neuronopathic involvement (*see Appendix D*);
   b. Documented mutation(s) in *IDS* gene known to result in a neuronopathic phenotype;

c. Both of the following (i and ii):
   i. Member has a relative clinically diagnosed with neuronopathic MPS II who has the same *IDS* gene mutation as the member;
   ii. Geneticist determines member has inherited a neuronopathic form of MPS II;
5. Member has not previously received hematopoietic stem cell transplantation;*
6. Member has not previously received an AAV-based gene therapy product;*
7. Dose does not exceed 2.9 x 10^{11} genome copies/g brain mass.*

Approval duration: 3 months (one intracisternal injection per lifetime)

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/ICHRA) 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/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) 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/ICHRA, 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/ICHRA, and CP.PMN.53 for Medicaid.

II. Continued Therapy*

**Criteria will mirror the clinical information from the prescribing information once FDA-approved*

A. Mucopolysaccharidosis II: Hunter Syndrome
1. Re-authorization is not permitted as RGX-121 is indicated to be dosed one time only.

Approval duration: Not applicable

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/ICHRA) 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/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) 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/ICHRA, 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/ICHRA, 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/ICHRA, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AAV: adeno-associated virus
BSID-III: Bayley Scales of Infant and Toddler Development, 3rd Edition
FDA: Food and Drug Administration
IDS: iduronate-2-sulfatase
MPS II: mucopolysaccharidosis type II
MSEL: Mullen Scales of Early Learning

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings [Pending]

- Contraindication(s): pending
- Boxed warning(s): pending

Appendix D: Neurocognitive Tests and Thresholds Demonstrating Neuronopathic MPS II

- Bayley Scales of Infant and Toddler Development, 3rd Edition (BSID-III) cognitive composite score at or below -1 standard deviation (85) from normative mean
- Two consecutive neurodevelopmental assessments that support a decline of ≥ 1 standard deviation on serial testing administered between 3 to 36 months apart from one of the following:
  - Mullen Scales of Early Learning (MSEL) domains of visual reception, expressive language, or fine motor
  - BSID-III domains of cognition, expressive language, or fine motor

V. Dosage and Administration [Pending]

Indication	Dosing Regimen	Maximum Dose
MPS II	2.9×10^{11} genome copies/g brain via a one-time intracisternal injection*	Pending

VI. Product Availability [Pending]

Pending

VII. References

1. ClinicalTrials.gov. CAMPSIITE™ RGX-121 gene therapy in subjects with MPS II (Hunter syndrome). Available at: https://clinicaltrials.gov/study/NCT03566043. Accessed May 21, 2026.
2. Scarpa M, Lampe C. Mucopolysaccharidosis Type II. 2007 Nov 6 [Updated 2026 Apr 28]. GeneReviews® [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2026. Available at: https://www.ncbi.nlm.nih.gov/books/NBK1274/. Accessed May 21, 2026.
3. Żuber Z, Kieć-Wilk B, Kałużny Ł, et al. Diagnosis and management of mucopolysaccharidosis type II (Hunter syndrome) in Poland. Biomedicines. 2023;11(6):1668.

Coding Implications [Pending]

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
Pending	Pending

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created pre-emptively	06.03.25	08.25
3Q 2026 annual review: no significant changes; added ICHRA line of business; updated language under Policy/Criteria to effectively redirect prior authorization reviews to Precision Drug Action Committee (PDAC) Utilization Management Review; references reviewed and updated.	04.22.26	08.26

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.