Preemptive policy: This is a P&T approved policy and can be used after the drug is FDA approved until it is superseded by an updated policy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: Zeleciment Rostudirsen (DYNE-251)

Reference Number: CP.PHAR.804
Effective Date: FDA Approval Date
Last Review Date: 11.26
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.

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Description

Zeleciment rostudirsen (DYNE-251®/™) is a phosphorodiamidate morpholino oligomer (PMO) conjugated to a fragment antibody (Fab) that binds to the transferrin receptor 1 (TfR1).

FDA Approved Indication(s) [Pending]

DYNE-251 is indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 51 skipping.

Limitation(s) of use: This indication is approved under accelerated approval based on an increase in dystrophin in skeletal muscle observed in some patients treated with DYNE-251. Continued approval for this indication may be contingent upon verification of a clinical benefit in confirmatory trials.

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 may **require medical director review.**

It is the policy of health plans affiliated with Centene Corporation® that DYNE-251 may be **medically necessary*** when the following criteria are met:

**** DYNE-251 was FDA-approved based on an observed increase in dystrophin in skeletal muscle, but it is unknown if that increase is clinically significant. Continued FDA-approval for this indication may be contingent upon verification of a clinical benefit in confirmatory trials. [Pending]***

I. Initial Approval Criteria*

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

A. Duchenne Muscular Dystrophy (must meet all)**:**

1. Diagnosis of DMD with mutation amenable to exon 51 skipping (*see Appendix D*) confirmed by genetic testing;*
2. Prescribed by or in consultation with a neurologist;
3. Age ≤ 16 years at therapy initiation;*
4. Member has all of the following assessed within the last 30 days (a, b, and c):

a. Upper limb function with Brooke Upper Extremity Scale score of 1 or 2 (*see Appendix D*);
b. Stable cardiac function with left ventricular ejection fraction (LVEF) ≥ 50%;
c. If age ≥ 7 years, stable pulmonary function with predicted forced vital capacity (FVC) ≥ 40%;

5. If member is non-ambulatory (e.g., unable to walk with or without assistive devices, wheelchair dependent), member has been non-ambulatory for < 2 years;
6. Inadequate response (as evidenced by a significant decline in ambulatory/upper limb function, LVEF, or FVC) despite adherent use of an oral corticosteroid (e.g., prednisone, deflazacort [Emflaza®], Agamree®)* for ≥ 6 months, unless contraindicated or clinically significant adverse effects are experienced;^
   **Prior authorization is required for Emflaza and Agamree*
   ^For Illinois HIM requests, the step therapy requirement above does not apply as of 1/1/2026 per IL HB 5395
7. DYNE-251 is prescribed concurrently with an oral corticosteroid, unless contraindicated or clinically significant adverse effects are experienced;
8. DYNE-251 is not prescribed concurrently with other exon-skipping therapies (e.g., Amondys 45®, Exondys 51®, Vyondys 53®, Viltepso®);
9. Member has not previously received gene replacement therapy for DMD (e.g., Elevidys®);
10. Dose does not exceed 20 mg/kg every 4 weeks.*

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/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. Duchenne Muscular Dystrophy (must meet all)**:**

1. Currently receiving medication for DMD with mutation amenable to exon 51 skipping or member has previously met initial approval criteria;*

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2. Member is responding positively to therapy as evidenced by one of the following (a or b):
   a. All of the following assessed within the last 6 months (i, ii, and iii):
      i. Upper limb function with Brooke Upper Extremity Scale score of 1 or 2 (*see Appendix D*);
      ii. Stable cardiac function with LVEF ≥ 50%;
      iii. If age ≥ 7 years, stable pulmonary function with predicted FVC ≥ 40%;
   b. Member has received this medication via a healthcare insurer without meeting the requirements above (see criterion 2a), and medical record shows improved or stable LVEF and FVC, assessed within the last 6 months;
3. Member has been assessed by a neurologist within the last 6 months;
4. DYNE-251 is prescribed concurrently with an oral corticosteroid, unless contraindicated or clinically significant adverse effects are experienced;
5. DYNE-251 is not prescribed concurrently with other exon-skipping therapies (e.g., Amondys 45, Exondys 51, Vyondys 53, Viltepso);
6. Member has not previously received gene replacement therapy for DMD (e.g., Elevidys);
7. If request is for a dose increase, new dose does not exceed 20 mg/kg every 4 weeks.*

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/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.

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IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AAN: American Academy of Neurology
DMD: Duchenne muscular dystrophy
FDA: Food and Drug Administration
FVC: forced vital capacity
ICER: Institute for Clinical and Economic Review
LVEF: left ventricular ejection fraction

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
prednisone*	0.3-0.75 mg/kg/day or 10 mg/kg/weekend PO	Based on weight
deflazacort (Emflaza®)	0.9 mg/kg/day PO QD	Based on weight
Agamree® (vamorolone)	6 mg/kg/day PO QD (up to a maximum of 300 mg/day) • If member has mild (Child-Pugh A) to moderate (Child-Pugh B) hepatic impairment: 2 mg/kg/day PO QD (up to a maximum of 100 mg/day) • If co-administered with strong CYP3A4 inhibitors (e.g., itraconazole): 4 mg/kg/day PO QD (up to a maximum of 200 mg/day)	See regimen

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.
**Off-label*

Appendix C: Contraindications/Boxed Warnings [Pending]

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

Appendix D: General Information

- Common mutations amenable to exon 51 skipping include: 3-50, 4-50, 5-50, 6-50, 9-50, 10-50, 11-50, 13-50, 14-50, 15-50, 16-50, 17-50, 19-50, 21-50, 23-50, 24-50, 25-50, 26-50, 27-50, 28-50, 29-50, 30-50, 31-50, 32-50, 33-50, 34-50, 35-50, 36-50, 37-50, 38-50, 39-50, 40-50, 41-50, 42-50, **43-50, 45-50, 47-50, 48-50, 49-50, 50, 52**, 52-61, 52-63, 52-64, 52-66, 52-76. The bolded mutations are deletions which make up > 97% of all mutations amenable to skipping exon 51 according to the DMD registration database.
- Corticosteroids are routinely used in DMD management with established efficacy in slowing decline of muscle strength and function (including motor, respiratory, and cardiac). They are recommended for all DMD patients per the American Academy of Neurology (AAN) and DMD Care Considerations Working Group; in addition, the AAN guidelines have been endorsed by the American Academy of Pediatrics, the American

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Association of Neuromuscular & Electrodiagnostic Medicine, and the Child Neurology Society.
  - The DMD Care Considerations Working Group guidelines, which were updated in 2018, continue to recommend corticosteroids as the mainstay of therapy while dystrophin restoration therapies like exon-skipping therapies are mentioned only as emerging treatments.
  - In an evidence report published August 2019, the Institute for Clinical and Economic Review (ICER) states that current evidence is insufficient to conclude that Exondys 51, a similarly indicated exon-skipping therapy for DMD amenable to exon 51 skipping, has net clinical benefit when added to corticosteroids and supportive care versus corticosteroids and supportive care alone.
- Prednisone is the corticosteroid with the most available evidence. A second corticosteroid commonly used is deflazacort, which was FDA approved for DMD in February 2017. On October 2023, a third corticosteroid, vamorolone, was approved by the FDA for DMD.
- DELIVER, the phase 1/2 study used to support the FDA approval of DYNE-251*, enrolled ambulatory and non-ambulatory patients age 4-16 years old with a Brooke Upper Extremity Scale score of 1-2, LVEF ≥ 50%, and FVC ≥ 40% at baseline.
  - The Brooke Upper Extremity Scale is a 6-point classification that summarizes upper limb function:
    - 1: Starting with normal movement where arms can fully move up and in a wide circle above the head.
    - 2: Raising arms above the head only by bending the elbows or changing the path of the movement.
    - 3: Being unable to raise hands above the head, but able to lift an 8-ounce glass of water to the mouth.
    - 4: Raising hands to the mouth, but unable to lift an 8-ounce cup or glass of water to the mouth.
    - 5: Being unable to raise hands to the mouth, but still able to use hands to hold a pen or pick up small items like pennies from a table.
    - 6: Being unable to raise hands to the mouth and having no useful function of the hands.

V. Dosage and Administration [Pending]

Indication	Dosing Regimen	Maximum Dose
DMD*	20 mg/kg IV every 4 weeks*	20 mg/kg/4 weeks*

VI. Product Availability [Pending]

Pending

VII. References

1. ClinicalTrials.gov. Safety, tolerability, pharmacodynamic, efficacy, and pharmacokinetic study of DYNE-251 in participants with Duchenne muscular dystrophy amenable to exon 51 skipping (DELIVER). Available at: https://clinicaltrials.gov/study/NCT05524883. Accessed July 30, 2026.

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2. Shieh P, Campbell C, Deconink N, et al. Safety and efficacy of DYNE-251 in males with DMD mutations amenable to exon 51 skipping (S31.010). Neurology. 2025; 104(7_Supplement_1): 3728.
3. ClinicalTrials.gov. Efficacy, safety, and tolerability of zeleciment rostudirsen (DYNE-251) administered intravenously every 4 weeks in ambulatory participants with Duchenne muscular dystrophy (FORZETTO). Available at: https://clinicaltrials.gov/study/NCT07608432. Accessed July 30, 2026.
4. Birnkrant DJ, Bushby K, Bann CM, et al. Diagnosis and management of Duchenne muscular dystrophy, part 1: diagnosis, and neuromuscular, rehabilitation, endocrine, and gastrointestinal and nutritional management. Lancet Neurol. 2018; 17: 251-267.
5. Gloss D, Moxley RT, Ashwal S, Oskoui M. Practice guideline update summary: corticosteroid treatment of Duchenne muscular dystrophy. Neurology. 2016; 86: 465-472.
6. Institute for Clinical and Economic Review. Deflazacort, eteplirsen, and golodirsen for Duchenne muscular dystrophy: Effectiveness and value. Published August 15, 2019. Available at: https://icer.org/wp-content/uploads/2020/10/Corrected_ICER_DMD-Final-Report_042222.pdf. Accessed July 30, 2026.

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	07.30.26	11.26

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

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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.

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