itvisma®
(onasemnogene abeparvovec-brve)
suspension for intrathecal injection

Prior Authorizations and Appeals Guide

A Step-by-Step Guide for Health Care Professionals and Access Coordinators to Help Navigate Coverage for Adult and Pediatric Patients Aged 2 Years and Older With Spinal Muscular Atrophy

INDICATION

ITVISMA is indicated for the treatment of spinal muscular atrophy (SMA) in adult and pediatric patients 2 years of age and older with confirmed mutation in *survival motor neuron 1 (SMN1)* gene.

IMPORTANT SAFETY INFORMATION

BOXED WARNING: Serious Liver Injury

Acute serious liver injury can occur with ITVISMA. Hepatotoxicity, with elevated alanine transaminase (ALT) and/or aspartate transaminase (AST) levels, has occurred with ITVISMA. Patients with preexisting hepatic impairment or acute hepatic viral infection may be at higher risk of liver injury. To mitigate potential aminotransferase elevations, administer systemic corticosteroid before and after ITVISMA injection. Prior to ITVISMA injection, assess liver function by clinical examination and laboratory testing. Continue to monitor liver function for at least 3 months after ITVISMA administration, and at other times as clinically indicated. In case hepatic injury is suspected, further testing is recommended. Promptly consult with a gastroenterologist or hepatologist, as necessary.

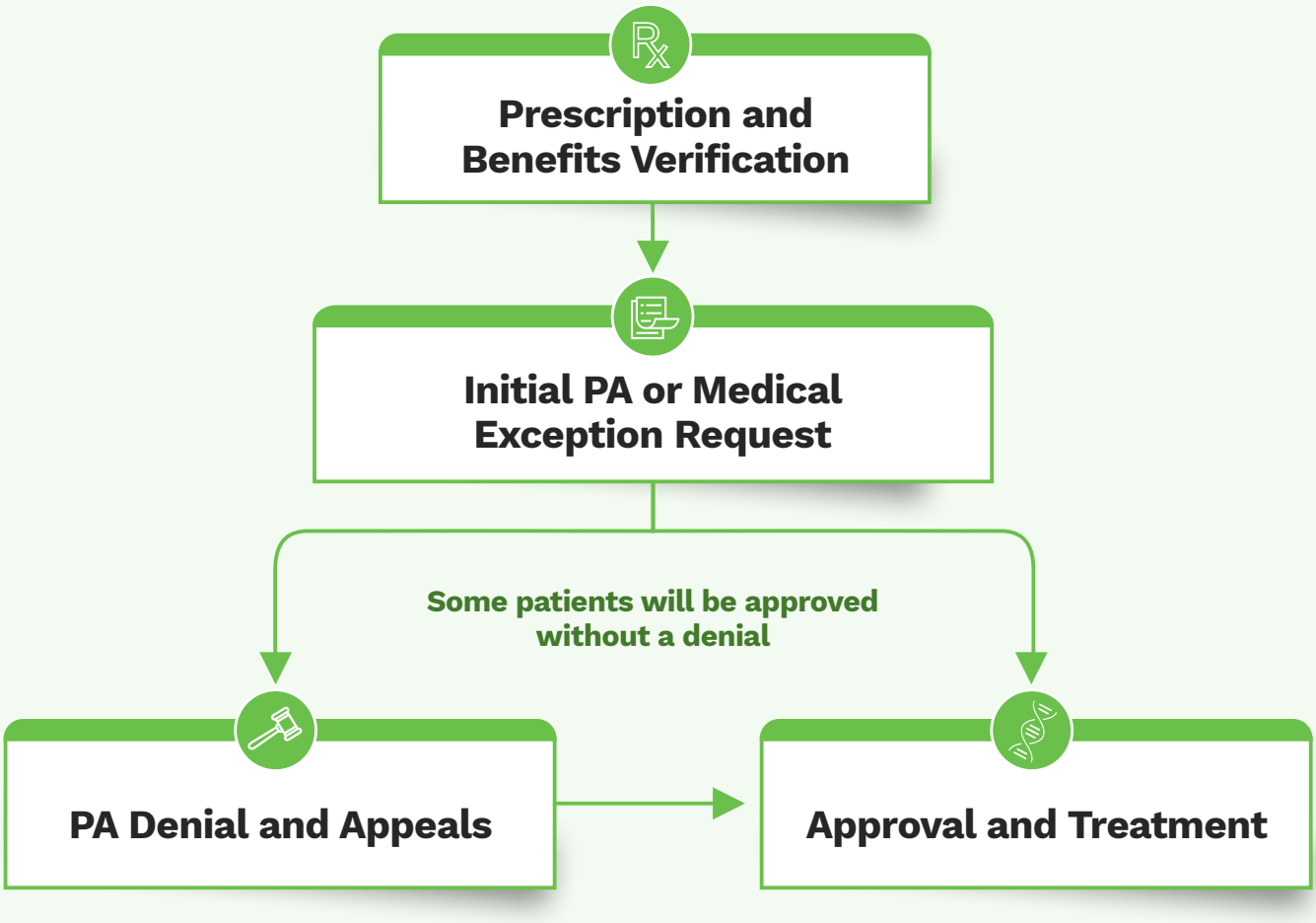
Please see Indication and Important Safety Information on page 15 and click here for Full Prescribing Information, including Boxed WARNING.

Key Steps in the Insurance Coverage Approval Process

Navigating the insurance approval process for ITVISMA® (onasemnogene abeparvovec-brve)

Once the decision to prescribe ITVISMA is made, determine the specific coverage criteria for your patient's health plan, including any patient out-of-pocket costs, methods of acquisition or sites of care required by the health plan, and coding and billing information.

- Coverage requirements for ITVISMA may vary from patient to patient based on their individual health plan and circumstances
- It is important to review and understand the health plan's eligibility requirements specific to ITVISMA



For assistance throughout the insurance approval process for ITVISMA

CONTACT your RAAD, your access and reimbursement specialist at Novartis

CALL Novartis Patient Support™ at **1-855-441-4363, Monday through Friday (8 AM to 8 PM ET)**

PA, prior authorization; RAAD, Regional Account Associate Director.

Please see Indication and Important Safety Information on page 15 and click here for Full Prescribing Information, including Boxed WARNING.

Required Testing for ITVISMA® (onasemnogene abeparvovec-brve)

Before receiving ITVISMA, patients must have a genetically confirmed SMA diagnosis, baseline testing for the presence of anti-AAV9 antibodies, and lab assessments to ensure eligibility and safe administration.[1] These tests can be ordered by the referring or treating physician. As a reminder, some patients may have already had genetic confirmation tests completed.

Tests typically required for ITVISMA

- ☐ Genetic confirmation of SMA diagnosis or historical documentation of prior test
- ☐ Baseline testing for the presence of anti–AAV9 antibodies[1]
- ☐ Lab assessments for liver function (clinical examination, AST, ALT, albumin, prothrombin time, PTT, INR, and total bilirubin)[1]
- ☐ Creatinine and complete blood count (including hemoglobin and platelet count)[1]
- ☐ The pregnancy status of females of reproductive potential should be verified prior to treatment with ITVISMA[1]

Novartis Laboratory Testing Program

- Novartis partners with Athena® Diagnostics and CTL to sponsor the Novartis Laboratory Testing Program to provide test kits and cover the cost of diagnostic tests for SMA genetic testing and anti–AAV9 antibody tests*
- Athena Diagnostics offers tests to confirm *SMN1* deletion, *SMN2* copy numbers, and anti–AAV9 antibody tests. CTL offers anti–AAV9 antibody tests
- To order pretreatment test kits (*SMN1*, *SMN2*, anti–AAV9 antibody) for patients who are being considered for treatment with ITVISMA, contact Novartis Patient Support at **1-855-441-4363**
- Testing partners can be contacted directly for further information
  - Athena Diagnostics at **1-800-394-4493**
  - CTL at **1-216-791-5084**

Enrollment in Novartis Patient Support is not required to order test kits or participate in testing sponsored by Novartis.

Perform all lab tests as soon as possible and confirm results align with PA requirements based on ITVISMA Prescribing Information and payor requirements prior to submission

AAV9, adeno-associated virus serotype 9; ALT, alanine aminotransferase; AST, aspartate aminotransferase; CTL, Cellular Technology Limited; INR, international normalized ratio; PTT, partial thromboplastin time; SMA, spinal muscular atrophy; *SMN1*, *survival motor neuron 1* gene; *SMN2*, *survival motor neuron 2* gene.

*The least dilute concentration for Athena Diagnostics, 1:25, is the reference range for the test; a 1:50 dilute concentration is used to determine the reference range for CTL test results.

Preparing the Initial Prior Authorization Submission

Document your patient's clinical history in the PA request form

Payors may require specific documentation for patients prescribed ITVISMA® (onasemnogene abeparvovec-brve) based on patient-specific circumstances and heath plan criteria. Coverage requirements may vary based on your patient's health plan, with some plans having less restrictive approval criteria than others, and some plans may require you use their PA form. However, there are certain criteria that will apply to all health plans.

Below is a list of PA criteria to help you prepare a thorough submission and potentially eliminate reasons for denial

- ☐ Confirm if health plan has a specific form required and, if so, complete all required fields
- ☐ Letter of medical necessity
  - As a proactive measure to avoid a delay in treatment if a denial occurs, it is recommended that you submit a PA letter or letter of medical necessity with the initial PA Request Form submission
  - ☐ Genetic testing and confirmation of SMA diagnosis, including ICD-10-CM code(s) and testing dates
    - ☐ Confirmation of *SMN1* gene deletion
    - ☐ Documentation of the onset of clinical signs and symptoms of SMA
  - ☐ Baseline anti–AAV9 antibody test[1]
  - ☐ Liver function tests (clinical exam, AST, ALT, albumin, prothrombin time, PTT, INR, and total bilirubin)[1]
  - ☐ Creatinine and complete blood count (including hemoglobin and platelet count)[1]
  - ☐ Motor function testing results (eg, HFMSE)
  - ☐ Verification of pregnancy status for female patients with reproductive potential[1]
  - ☐ Patient age[1]
  - ☐ Ambulatory status
  - ☐ Age of symptom onset
  - ☐ Documentation that the prescriber is a specialist (ie, pediatric neurologist, neuromuscular specialist, or neurologist)
  - ☐ For patients switching treatment, prior treatment history and treatment response
    - ☐ Information about disease progression during use of prior DMT
    - ☐ Attestation of no concomitant DMT
    - ☐ Rationale for switch
    - ☐ Attestation that patient has not been treated with onasemnogene abeparvovec-xioi
  - ☐ Attestation that patient is clinically stable in their overall baseline health status (eg, hydration and nutritional status, absence of infection, respiratory status)[1]
  - ☐ ITVISMA Prescribing Information
  - ☐ Relevant supporting publications

Click here to access the PA letter template or click the Resources tab above for additional resources to help prepare for submission

For help navigating the PA process, contact your RAAD or Novartis Patient Support at **1-855-441-4363**, **Monday through Friday (8 AM to 8 PM ET)** for guidance based on your patient's individual health plan

DMT, disease-modifying therapy; HFMSE, Hammersmith Functional Motor Scale—Expanded; ICD-10-CM, International Classification of Diseases, Tenth Revision, Clinical Modification.

Preparing the Initial Medical Exception Request

If the patient's health plan does not have a policy in place or a patient does not fully meet policy criteria for ITVISMA® (onasemnogene abeparvovec-brve), you will need to complete a medical exception request. If the plan has its own medical exception form, ensure all required information is provided. Contact your RAAD for information on plan-specific exception forms.

Include all pertinent information and required documentation in your exception request

- ☐ Completed plan-specific medical exception request form, if available
- ☐ Letter of medical necessity
  - ☐ **Rationale why ITVISMA is appropriate/necessary for your patient**
  - ☐ Genetic testing and diagnosis confirmation of SMA diagnosis, including ICD-10-CM code(s) and testing dates
    - ☐ Confirmation of *SMN1* gene deletion
    - ☐ Documentation of the onset of clinical signs and symptoms of SMA
  - ☐ Baseline anti–AAV9 antibody test[1]
  - ☐ Liver function tests (clinical exam, AST, ALT, albumin, prothrombin time, PTT, INR, and total bilirubin)[1]
  - ☐ Creatinine and complete blood count (including hemoglobin and platelet count)[1]
  - ☐ Motor function testing results (eg, HFMSE)
  - ☐ Verification of pregnancy status for female patients with reproductive potential[1]
  - ☐ Patient age[1]
  - ☐ Ambulatory status
  - ☐ Age of symptom onset
  - ☐ Documentation that the prescriber is a specialist (ie, pediatric neurologist, neuromuscular specialist, or neurologist)
  - ☐ For switch patients, prior treatment history and treatment response
    - ☐ Information about disease progression during use of prior DMT
    - ☐ Attestation of no concomitant DMT
    - ☐ Rationale for switch
    - ☐ Attestation that patient has not been treated with onasemnogene abeparvovec-xioi
  - ☐ Attestation that patient is clinically stable in their overall baseline health status (eg, hydration and nutritional status, absence of infection, respiratory status)[1]
  - ☐ ITVISMA Prescribing Information
  - ☐ Relevant supporting publications

Click here to access the medical necessity letter template or click the Resources tab above for additional resources to help prepare for submission

For guidance on the medical exception process, contact your RAAD or Novartis Patient Support at **1-855-441-4363, Monday through Friday (8 AM to 8 PM ET)**

Requesting Exceptions for Self-Funded Employer Gene Therapy Carve-Outs

Self-funded employer plans may choose to carve out gene therapies from their plans. In addition to the exception request checklist on the previous page, work with your patient to gather additional information to help them advocate for coverage with their employer, such as:

- Reviewing the **employer plan document**, available from the employer or their TPA. Patients or caregivers can request these files from the TPA or employer
- Writing a letter to the employer to **advocate for coverage**. You and the patient or caregiver can call Novartis Patient Support for additional information for writing this letter
- Reviewing the **employee handbook** for rights as an employee
- Contacting **advocacy groups** for information and support, including information on local labor laws
- Confirming the patient's Medicaid eligibility **here**
- Reviewing the ACA **here**

For guidance on the medical exception process, contact your RAAD or Novartis Patient Support at **1-855-441-4363, Monday through Friday (8 AM to 8 PM ET)**

ACA, Affordable Care Act; TPA, third-party administrator.

Submitting an Appeal

Understanding denial criteria

If the initial PA or medical exception request is denied, you will need to submit an appeal to the health plan. Review the patient-specific denial from the health plan and gather the necessary information to address the reason for the denial.

In your appeal, make sure to

- ☐ Complete the required plan-specific appeal form, if applicable
- ☐ Include a letter of appeal
  - ☐ Highlight the reason for denial and address it with specific rationale, being as detailed as possible
  - ☐ Reiterate the request for treatment
  - ☐ Request a peer-to-peer review with a specialist, such as a neuromuscular specialist, neurologist, or pediatric neurologist familiar with SMA, for further discussion and clarification
  - ☐ Include pertinent information and documentation from the initial submission, including
    - ☐ Patient history
    - ☐ ITVISMA® (onasemnogene abeparvovec-brve) Prescribing Information and clinical publications
    - ☐ Diagnostic test and functional assessment results
    - ☐ Letter of medical necessity or PA letter

Click here to access the appeal letter template or click the Resources tab above for additional resources to help prepare for submission

If you have any questions about the appeal process, contact your RAAD or Novartis Patient Support at **1-855-441-4363**, **Monday through Friday (8 AM to 8 PM ET)**

Preparing for a Peer-to-Peer Discussion

If your patient's health plan has issued a denial of coverage for ITVISMA® (onasemnogene abeparvovec-brve), you may have the option to appeal in writing or by phone via a peer-to-peer review. When meeting for a peer-to-peer discussion with a specialist such as a neuromuscular specialist, neurologist, or pediatric neurologist familiar with SMA, the reviewing peer may not have all the necessary documentation because these are done on a patient-by-patient basis.

BEFORE the meeting

To prepare for your peer-to-peer meeting, collect and review all documentation submitted to the payor

- ☐ Patient history and clinical documentation
- ☐ Claim form
- ☐ Prior authorization request
- ☐ Letter of medical necessity or PA letter
- ☐ Denial letters
- ☐ Letter of appeal
- ☐ ITVISMA Prescribing Information
- ☐ Supporting publications

DURING the meeting

- ☐ Take thorough notes
- ☐ Identify the outcome of the discussion
- ☐ Ensure alignment of all necessary documentation required for resubmission
- ☐ Request information about the next steps and timing for approval

Click here for additional information about ITVISMA

Escalating to External Review Board or Oversight Committee

Federal consumer protection standards require insurance companies to offer an external review process through a state or federal board.[2]

Information on the organization that handles the external review for your patient is included in the denial of the health plan's internal review or the patient's Explanation of Benefits[2]

A written request for external review must be **submitted within 4 months** of receiving notice of the denial[2]

The types of denials that can qualify for external review are[2]

- Denials involving medical judgment where a patient or provider disagrees with the health insurance plan
- Denials that involve a determination that a treatment is experimental or investigational
- Cancellation of coverage due to an insurer's claim that they were given false or incomplete information in the application for coverage

The decision of the external review board is final and the insurance company must comply with the outcome[2]

When submitting the request, include additional supporting documentation related to the request

- ☐ Written request for external review
- ☐ Patient history and clinical documentation
- ☐ ITVISMA® (onasemnogene abeparvovec-brve) Prescribing Information
- ☐ Letters sent to and received from the insurer regarding the claim
- ☐ Supporting publications
- ☐ Summary of the peer-to-peer discussion and outcome

Approval and Treatment

You and your staff have secured access to ITVISMA® (onasemnogene abeparvovec-brve) for your patient with SMA. Now it is time to schedule the injection and prepare for treatment.

If you have any questions, or for more information about ordering ITVISMA, please contact your RAAD

To prepare for treatment[1]

- ☐ Ensure patients have an up-to-date vaccination status and have baseline tests for the presence of anti–AAV9 antibodies
- ☐ Assess liver function (clinical examination, AST, ALT, albumin, prothrombin time, PTT, INR, and total bilirubin), obtain creatinine and complete blood count (including hemoglobin and platelet count)
- ☐ One day prior to ITVISMA injection, begin administration of systemic corticosteroids equivalent to oral prednisolone at 1 mg per kg of body weight per day (mg/kg/day) for 30 days (or longer based on liver function). Do not stop systemic corticosteroids abruptly. After the corticosteroid treatment period, taper prednisolone (or equivalent) as needed according to the clinical status and liver function testing. Please see full Prescribing Information for the recommended corticosteroid regimen
- ☐ Administer ITVISMA to patients who are clinically stable in their overall baseline health status (eg, hydration and nutritional status, absence of infection, respiratory status) prior to administration
  - Postpone ITVISMA in patients with active or recent infections, until the infection has resolved, and the patient is clinically stable. Clinical signs or symptoms of infection should not be evident at the time of ITVISMA injection

Prior to ordering product, your site of care needs to be onboarded. To initiate the onboarding process, contact your RAAD

Access Resources

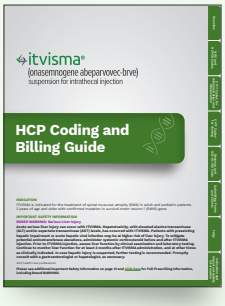
The following resources provide additional support during the PA submission and appeals process for ITVISMA® (onasemnogene abeparvovec-brve).

Novartis Patient Support Start Form

Click here to access the Start Form to enroll your patient in Novartis Patient Support for ITVISMA

HCP Coding and Billing Guide

Click here to access the HCP Coding and Billing Guide, a detailed guide which provides information related to codes and forms required for billing and reimbursement for ITVISMA



In addition to these resources, the following pages provide sample letters of PA requests, medical necessity, and appeal that you can use as guides to write letters on behalf of your patient

HCP, health care professional.

Access Resources (cont)

NOTE: This Sample Prior Authorization Letter is a template to help you write your own letter to health plans. Blue text in brackets is to be updated reflecting relevant information for you, your practice, and your patient.

ITVISMA® (onasemnogene abeparvovec-brve) Sample Prior Authorization Letter

[Date]
[Medical Director name]
[Health plan]
[Address]

Re: [Patient name]
[Policy number, ID, and group number]
[Date of birth]

To Whom It May Concern,

My name is [HCP name], and I am a [medical specialty] caring for [Patient name], who is currently a member of [health plan]. I am writing to request prior authorization of ITVISMA® (onasemnogene abeparvovec-brve) for the treatment of this patient for [diagnosis and ICD-10-CM code(s)]. [Included please find a statement explaining why these preferred therapies are not appropriate for my patient]. The following information supports my recommendation for treatment with ITVISMA:
I have attached relevant medical records, including the patient's diagnosis, test results, and treatment history.

[***Include a summary of the patient's treatment history:***
☐ Include confirmation of *survival motor neuron 1* gene (*SMN1*) deletion, documentation of clinical signs and symptoms, functional assessment results (eg, Hammersmith Functional Motor Scale—Expanded [HFMSE], Revised Upper Limb Module [RULM])
☐ Baseline testing for the presence of anti–adeno-associated virus serotype 9 (AAV9) antibodies
☐ Include lab assessments for liver function (clinical exam, aspartate aminotransferase [AST], alanine aminotransferase [ALT], albumin, prothrombin time, partial thromboplastin time [PTT], international normalized ratio [INR], and total bilirubin), creatinine, and complete blood count (including hemoglobin and platelet count)
☐ Provide history of treatment if applicable, including
  ☐ Prior therapy (eg, nusinersen and/or risdiplam)
  ☐ Duration of therapy
  ☐ Reason for discontinuation
☐ Include clinical support for prescribing ITVISMA, including the ITVISMA Prescribing Information and relevant peer-reviewed articles]

Given [Patient name's] current condition and treatment history, I believe ITVISMA should be authorized to treat spinal muscular atrophy (SMA) for this patient. Please do not hesitate to contact me by calling [office phone number] if you require additional information or would like to discuss this case further. The prior authorization decision may be faxed to [fax number] or mailed to [HCP business office address]. Thank you for your prompt attention to this matter.

Sincerely,

[HCP name and signature]
[Specialty, name of practice, phone number]
Encl: [Medical records, ITVISMA Prescribing Information]

Access Resources (cont)

NOTE: This Sample Letter of Medical Necessity is a template to help you write your own letter to health plans. Blue text in brackets is to be updated reflecting relevant information for you, your practice, and your patient.

ITVISMA® (onasemnogene abeparvovec-brve) Sample Letter of Medical Necessity

[Date]
[Medical Director name]
[Health plan]
[Address]

Re: [Patient name]
[Policy number, ID, and group number]
[Date of birth]

My name is [HCP name], and I am a [medical specialty] caring for [Patient name] who is currently a member of [health plan]. I am writing to explain why, in my clinical judgment, ITVISMA® (onasemnogene abeparvovec-brve) is required for the treatment of this patient for [diagnosis and ICD-10-CM code(s)]. [If you are writing this letter for a medical or tiering exception request, provide a statement of the exception you are requesting and the reason for the request.] The following information supports my recommendation for treatment with ITVISMA:

Summary of Patient's Medical History and Diagnosis
[***Include a summary of the patient's diagnosis and current condition:*** *Be sure to attach relevant medical records that support this information. The following topics are examples of information you may want to include:*
☐ Confirmation of *survival motor neuron 1* gene (*SMN1*) deletion
☐ Baseline testing for the presence of anti–adeno-associated virus serotype 9 (AAV9) antibodies
☐ Lab assessments for liver function (clinical exam, aspartate aminotransferase [AST], alanine aminotransferase [ALT], albumin, prothrombin time, partial thromboplastin time [PTT], international normalized ratio [INR], and total bilirubin), creatinine, and complete blood count (including hemoglobin and platelet count)
☐ Documentation of clinical signs and symptoms
☐ Functional assessment results (eg, Hammersmith Functional Motor Scale—Expanded [HFMSE], Revised Upper Limb Module [RULM])
☐ History of treatment if applicable]

Treatment History
[***Include a summary of your patient's treatment history:***
☐ Comprehensive list of prior therapies for spinal muscular atrophy (SMA) (eg, nusinersen and/or risdiplam), including
  ☐ Duration of therapy
  ☐ Reason for discontinuation]

Rationale for Treatment
[***Provide your rationale for choosing ITVISMA:***
☐ Include clinical support for prescribing ITVISMA (This may be clinical trial data found in the ITVISMA Prescribing Information)
☐ Explain why the health plan's preferred therapies are not appropriate for your patient
☐ If you are writing this letter for an exception request, provide a statement of the patient's financial hardship when appropriate]

Given [Patient name's] current condition and treatment history, I believe ITVISMA is the most medically appropriate and necessary therapy to treat spinal muscular atrophy for this patient. I have included relevant medical notes supporting my recommendation. Please feel free to contact me, [HCP name, NPI number] by calling [office phone number] to answer any additional questions or to participate in a peer-to-peer review discussing the necessity of ITVISMA for this patient. The coverage determination decision may be faxed to [HCP fax number] or mailed to [HCP business office address]. I look forward to your timely approval.

Sincerely,

[HCP name and signature]
[Specialty, name of practice, phone number]
Encl: [Medical records, ITVISMA Prescribing Information]

Access Resources (cont)

NOTE: This Sample Letter of Appeal is a template to help you write your own letter to health plans. Blue text in brackets is to be updated reflecting relevant information for you, your practice, and your patient.

ITVISMA® (onasemnogene abeparvovec-brve) Sample Letter of Appeal

[Date]
[Medical Director name]
[Health plan]
[Address]

Re: [Patient name]
[Policy number, ID, and group number]
[Date of birth]

To Whom It May Concern,

My name is [HCP name], and I am a [medical specialty] caring for [Patient name], who is currently a member of [health plan]. I prescribed ITVISMA® (onasemnogene abeparvovec-brve) for this patient to treat [diagnosis and ICD-10-CM code(s)] and submitted a [Prior Authorization/Medical Exception Request] on [date of submission]. The request was denied on [date of denial and reference number] and the reason given was [reason from the health plan's denial letter]. I request a formal appeal of your denial for ITVISMA, based on my review of the patient's diagnosis, care plan, and clinical guidelines for treatment. I maintain that ITVISMA is the appropriate therapy for [Patient name].
The following information supports my recommendation for treatment with ITVISMA:

Summary of Patient's Medical History and Diagnosis
[***Include a summary of the patient's diagnosis and current condition:*** *Be sure to attach relevant medical records that support this information. The following topics are examples of information you may want to include:*

- ☐ Patient's diagnosis and date of diagnosis
- ☐ Confirmation of *survival motor neuron 1* gene (*SMN1*) deletion
- ☐ Baseline testing for the presence of anti–adeno-associated virus serotype 9 (AAV9) antibodies
- ☐ Include lab assessments for liver function (clinical exam, aspartate aminotransferase [AST], alanine aminotransferase [ALT], albumin, prothrombin time, partial thromboplastin time [PTT], international normalized ratio [INR], and total bilirubin), creatinine, and complete blood count (including hemoglobin and platelet count)
- ☐ Documentation of clinical signs and symptoms
- ☐ Functional assessment results (eg, Hammersmith Functional Motor Scale—Expanded [HFMSE], Revised Upper Limb Module [RULM])]

Treatment History
[***Include a summary of your patient's treatment history:***

- ☐ Comprehensive list of prior therapies for spinal muscular atrophy (SMA) (eg, nusinersen and/or risdiplam), including
  - ☐ Duration of therapy
  - ☐ Reason for discontinuation]

Rationale for Treatment
[***Provide your rationale for choosing ITVISMA:***

- ☐ Include clinical support for prescribing ITVISMA (This may be clinical trial data found in the ITVISMA Prescribing Information)
- ☐ Ensure that you clearly address the health plan's reason(s) for denial. If the plan requires step therapy, provide an explanation indicating why the treatments specified are not appropriate for your patient
- ☐ Provide your professional opinion of the patient's likely prognosis or disease progression without treatment with ITVISMA]

Given [Patient name's] current condition and treatment history, I believe ITVISMA is the most medically appropriate and necessary therapy to treat spinal muscular atrophy for this patient and would appreciate your prompt reconsideration of this denial.

I have included a copy of the denial letter along with relevant medical notes in response to the denial. Please feel free to contact me, [HCP name, NPI number], by calling [office phone number] to answer any additional questions or to participate in a peer-to-peer review discussing the necessity of ITVISMA for this patient. The appeal decision may be faxed to [fax number] or mailed to [HCP business office address]. I look forward to your timely approval.

Sincerely,

[HCP name and signature]
[Specialty, name of practice, phone number]

Encl: [Denial letter, medical records, ITVISMA Prescribing Information]

Indication and Important Safety Information

itvisma®
(onasemnogene abeparvovec-brve)
suspension for intrathecal injection

INDICATION

ITVISMA is indicated for the treatment of spinal muscular atrophy (SMA) in adult and pediatric patients 2 years of age and older with confirmed mutation in *survival motor neuron 1 (SMN1)* gene.

IMPORTANT SAFETY INFORMATION

BOXED WARNING: Serious Liver Injury

Acute serious liver injury can occur with ITVISMA. Hepatotoxicity, with elevated alanine transaminase (ALT) and/or aspartate transaminase (AST) levels, has occurred with ITVISMA. Patients with preexisting hepatic impairment or acute hepatic viral infection may be at higher risk of liver injury. To mitigate potential aminotransferase elevations, administer systemic corticosteroid before and after ITVISMA injection. Prior to ITVISMA injection, assess liver function by clinical examination and laboratory testing. Continue to monitor liver function for at least 3 months after ITVISMA administration, and at other times as clinically indicated. In case hepatic injury is suspected, further testing is recommended. Promptly consult with a gastroenterologist or hepatologist, as necessary.

WARNINGS AND PRECAUTIONS

Thrombocytopenia

Transient decreases in platelet counts were observed within the first week after ITVISMA administration. Monitor platelet counts before ITVISMA injection and on a regular basis afterwards until platelet counts return to baseline.

Peripheral Sensory Neuropathy

Peripheral sensory neuropathy has occurred with ITVISMA administration with onset seen at approximately 3 weeks post-injection in clinical studies. Consider complete neurologic evaluation and other testing and/or symptom management based on the patient's clinical presentation.

Thrombotic Microangiopathy

Thrombotic microangiopathy (TMA) may occur with ITVISMA administration and can result in life-threatening or fatal outcomes. Monitor platelet counts on a regular basis following ITVISMA injection, as well as signs and symptoms of TMA. Consult a hematologist and/or nephrologist immediately to manage TMA as clinically indicated.

Elevated Cardiac Troponin I

Increases in cardiac troponin I levels have occurred following ITVISMA administration. Consider cardiac evaluation after ITVISMA administration and consult a cardiologist as needed.

AAV Vector Integration and Risk of Tumorigenicity

There is a theoretical risk of tumorigenicity due to integration of AAV vector DNA into the genome. The clinical relevance of individual integration events is unknown, but it is acknowledged that individual integration events could potentially contribute to a risk of tumorigenicity. Report cases of tumor development in patients who received ITVISMA to Novartis Gene Therapies, Inc. at 1-833-828-3947.

ADVERSE EVENTS

The most common adverse reactions that occurred in ≥2% of patients treated with ITVISMA were upper respiratory tract infection, pyrexia, upper gastrointestinal symptoms, hepatic enzymes increased, headache, dizziness, pain in extremity, thrombocytopenia, and sensory disturbance.

Please click here for Full Prescribing Information.

References: 1. ITVISMA. Prescribing information. Novartis Gene Therapies, Inc. **2.** Healthcare.gov. External review. Accessed October 14, 2025. https://www.healthcare.gov/appeal-insurance-company-decision/external-review/

NOVARTIS

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080