

## Vyondys 53® (Golodirsen)

**Policy Number:** 2026D0088I  
**Effective Date:** May 1, 2026

[➔ Instructions for Use](#)

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<b>Related Commercial Policy</b>
<ul style="list-style-type: none"> <li><a href="#">Provider Administered Drugs – Site of Care</a></li> </ul>
<b>Community Plan Policy</b>
<ul style="list-style-type: none"> <li><a href="#">Vyondys 53® (Golodirsen)</a></li> </ul>

### Application

#### UnitedHealthcare Commercial

This Medical Drug Policy applies to UnitedHealthcare Commercial benefit plans.

#### UnitedHealthcare Individual Exchange

This Medical Drug Policy applies to Individual Exchange benefit plans.

### Coverage Rationale

[➔ See Benefit Considerations](#)

**Vyondys 53 (golodirsen) may be covered for the treatment of Duchenne muscular dystrophy (DMD) in patients who meet all of the following criteria:**

#### Initial Therapy

- Diagnosis of Duchenne muscular dystrophy by, or in consultation with, a neurologist with expertise in the diagnosis of DMD; **and**
- Submission of medical records (e.g., chart notes, laboratory values) confirming the mutation of the DMD gene is amenable to exon 53 skipping; **and**
- **One** of the following:
  - Submission of medical records (e.g., chart notes, laboratory values) confirming that the patient has a 6-Minute Walk Test (6MWT) ≥ 300 meters while walking independently (e.g., without side-by-side assist, cane, walker, wheelchair, etc.) prior to beginning Vyondys 53 therapy; **or**
  - **Both** of the following:
    - Submission of medical records (e.g., chart notes) confirming that the patient is ambulatory **without** needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.); **and**
    - **One** of the following:
      - Patient has achieved a score of greater than 17 on the North Star Ambulatory Assessment (NSAA); **or**
      - Patient has achieved a time to rise (TTR) of less than 7 seconds
- and**
- **One** of the following:

- Patient has not previously received gene therapy [e.g., Elevidys (delandistrogene moxparvovec-rokl)] for the treatment of DMD; **or**
- **Both** of the following:
  - Patient has previously received gene therapy [e.g., Elevidys (delandistrogene moxparvovec-rokl)] for the treatment of DMD; **and**
  - Submission of medical records (e.g., chart notes, laboratory values) documenting a clinically meaningful functional decline resulting from loss of muscle strength/motor ability (e.g., loss of a motor milestone) since receiving gene replacement therapy [e.g., Elevidys (delandistrogene moxparvovec-rokl)]

**and**

- Vyondys 53 will not be used concomitantly with **any** of the following:
  - Duvyzat (givinostat); **or**
  - Other exon skipping therapies for DMD [e.g., Amondys (casimersen), Exondys 51 (eteplirsen), Viltepso (viltolarsen)]

**and**

- Prescribed by, or in consultation with, a neurologist with expertise in the treatment of DMD; **and**
- Dosing is in accordance with the United States Food and Drug Administration approved labeling; **and**
- Initial authorization will be for no more than 12 months

## Continuation Therapy

- Submission of medical records (e.g., chart notes) confirming that the patient is ambulatory **without** needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.); **and**
- Vyondys 53 will not be used concomitantly with **any** of the following:
  - Duvyzat (givinostat); **or**
  - Other exon skipping therapies for DMD [e.g., Amondys (casimersen), Exondys 51 (eteplirsen), Viltepso (viltolarsen)]

**and**

- Prescribed by, or in consultation with, a neurologist with expertise in the treatment of DMD; **and**
- Dosing is in accordance with the United States Food and Drug Administration approved labeling; **and**
- Reauthorization will be for no more than 12 months

## Unproven

**Vyondys 53 is unproven and not medically necessary for the treatment of other forms of muscular dystrophy (e.g., Becker muscular dystrophy).**

## Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
J1429	Injection, golodirsen, 10 mg

Diagnosis Code	Description
G71.01	Duchenne or Becker muscular dystrophy

## Background

Duchenne muscular dystrophy (DMD) is an X-linked disease that affects 1 in 3,500 – 5,000 live male births. DMD occurs as a result of mutations (mainly deletions) in the dystrophin gene. These mutations lead to an absence or a defect of the protein, dystrophin, resulting in progressive muscle degeneration, leading to loss of ambulation by age 8-14 years, and ultimately life-threatening complications including cardiomyopathy and respiratory insufficiency.

Golodirsen is an antisense oligonucleotide designed to bind to exon 53 of dystrophin pre-mRNA, resulting in exclusion of this exon during mRNA processing in patients with genetic mutations that are amenable to exon 53 skipping.

Approximately 8% of DMD patients have out of frame deletion mutations amenable to exon 53 skipping. Exon skipping is intended to allow for production of an internally truncated dystrophin protein.

## Benefit Considerations

Some Certificates of Coverage allow for coverage of experimental/investigational/unproven treatments for life-threatening illnesses when certain conditions are met. The member specific benefit plan document must be consulted to make coverage decisions for this service. Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances when certain conditions are met. Where such mandates apply, they supersede language in the benefit document or in the medical or drug policy.

## Clinical Evidence

Golodirsen 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 53 skipping.

In 2022, Servais et al published the results of the SKIP-NMD trial, a Phase 1/2, multicenter, 2-part study evaluating the long-term safety and efficacy of golodirsen in male patients aged 6 to 15 years with a DMD diagnosis and DMD gene amenable to exon 53 skipping. Patients age 6 to 15 years with stable cardiac and pulmonary function, and on a stable dose of corticosteroids for at least six months were included. Additional inclusion criteria included a baseline six-minute walk test (6MWT) of greater than 250m, a North Star Ambulatory Assessment (NSAA) score of greater than 17 or a rise time of less than 7 seconds. Part 1 was a randomized, double-blind, placebo-controlled, dose-titration study to assess the safety, tolerability, and pharmacokinetics of four escalating doses of intravenous (IV) golodirsen over 12 weeks, followed by a 9-week safety review. Part 2 was a long-term, 168-week, open-label evaluation of the biologic efficacy (at week 48), clinical efficacy (at week 144), and safety of golodirsen IV 30 mg/kg in patients with DMD amenable to exon 53 skipping. Primary endpoints were the change from baseline in 6MWT at 144 weeks and change in dystrophin protein levels at 48 weeks. Secondary endpoints included drug pharmacokinetics, change from baseline in FVC percent predicted, and change from baseline in dystrophin intensity at week 144. A total of 12 patients were included in Part 1 (golodirsen, n = 8; placebo, n = 4). All patients completed Part 1 and continued into Part 2. An additional 13 patients entered the trial at the start of Part 2, resulting in a final cohort of 25 patients receiving open label golodirsen 30 mg/kg/week in Part 2.

At week 48, exon skipping and dystrophin expression were both significantly increased (all  $p < 0.001$ ) among patients treated with golodirsen, and positive correlation was observed between exon 53 skipping and dystrophin production (Spearman's correlation coefficient: 0.50;  $p < 0.02$ ). Treatment with golodirsen (Parts 1 and 2 combined) resulted in a significant, 16.0-fold mean increase in dystrophin protein levels detected by western blot, from a baseline mean of 0.095% of normal levels, to 1.019% of normal at week 48 ( $p < 0.001$ ). Level of exon 53-skipped DMD gene expression was found to be increased by 28.9-fold ( $p < 0.001$ ), the percentage of dystrophin-positive fibers was increased by 13.5-fold ( $p < 0.001$ ), and myofiber regeneration decreased after golodirsen treatment, indicated by fewer fibers positive for fetal/developmental myosin at week 48 compared with baseline. Mean 6MWT distance at baseline was 405.8 m for golodirsen-treated patients and declined by 26.1, 64.6, and 99.0 m at weeks 48, 96, and 144, respectively. Two of 25 patients lost ambulation. Among golodirsen-treated patients, FVC%p declined by 8.4% over 3 years of treatment, from a mean FVC%p of 92.7% at baseline to 83.8% at week 144. Control patients' 6MWT distance declined by a mean of 181.4 m [standard deviation (SD), 151.6; range, -401 to 56] after 3 years compared with baseline. In contrast, golodirsen-treated patients declined by a mean of 99.0 m (SD, 123.8; range, -368 to 144) after 3 years ( $p = 0.067$  between groups). This difference emerged over time, as no difference between treated and untreated patients was observed at the time points before year 3. Among natural history controls, 5 of 19 patients (26%) had lost ambulation over 3 years, compared with 2 of 25 (9%) of those who received golodirsen ( $p = 0.21$ ).

ESSENCE is an ongoing 96-week, Phase 3, double-blind, placebo controlled, randomized clinical trial evaluating the efficacy of golodirsen in ambulatory, corticosteroid-treated, male patients with DMD amenable to exon 53 skipping. Eligible patients included those aged 6 to 13 years with a baseline 6MWT distance  $\geq 300$  and  $\leq 450$  m, stable pulmonary function, and on a stable dose of oral corticosteroids for at least 6 months. The primary endpoint is the 6MWT change from baseline to week 96. Secondary endpoints include 6MWT change from baseline at week 144, dystrophin protein change from baseline at weeks 48 and 96, ambulation assessments at weeks 96 and 144, and FVC%p change from baseline to weeks 96 and 144.

Golodirsen has not been studied in DMD that is not amenable to exon 53 skipping, nor in other forms of muscular dystrophy (e.g., Becker muscular dystrophy).

## Institute for Clinical and Economic Review (ICER)

On April 22, 2022, the Institute for Clinical and Economic Review (ICER) released a clinical report entitled, “Deflazacort, eteplirsen, and golodirsen for Duchenne muscular dystrophy: effectiveness and value.” In this report, ICER concluded that data for eteplirsen and golodirsen to be insufficient. Data on the exon-skipping drugs is extremely limited and randomized trial benefits are limited to the surrogate outcome of dystrophin levels. The small increases in dystrophin levels seen in the random controlled trials are of uncertain clinical significance. Observational studies comparing outcomes with historical controls have suggested potential functional benefits with eteplirsen, but these data may be confounded and effort dependent. Based on the current evidence, there are no particularly concerning safety issues with either drug but given the small numbers of patients and limited follow-up, harms could be missed.

## U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Vyondys 53 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 53 skipping. This indication is approved under accelerated approval based on an increase in dystrophin in skeletal muscle observed in some patients treated with Vyondys 53. Continued approval for this indication may be contingent upon verification of a clinical benefit in confirmatory trials.

## References

1. Vyondys 53 [package insert]. Cambridge, MA: Sarepta Therapeutics, Inc.; June 2024.
2. Frank DE, Schnell FJ, Akana C, et al. Increased dystrophin production with golodirsen in patients with Duchenne muscular dystrophy [published correction appears in *Neurology*. 2023 May 9;100(19):936]. *Neurology*. 2020;94(21):e2270-e2282.
3. Servais L, Mercuri E, Straub V, et al. Long-Term Safety and Efficacy Data of Golodirsen in Ambulatory Patients with Duchenne Muscular Dystrophy Amenable to Exon 53 Skipping: A First-in-human, Multicenter, Two-Part, Open-Label, Phase 1/2 Trial. *Nucleic Acid Ther*. 2022;32(1):29-39. doi:10.1089/nat.2021.0043.
4. Study of SRP-4045 and SRP-4053 in DMD Patients (ESSENCE) <https://clinicaltrials.gov/ct2/show/NCT02500381?term=golodirsen&cond=Duchenne+Muscular+Dystrophy&rank=3>. Accessed January 23, 2026.
5. Institute for Clinical and Economic Review (ICER). Deflazacort, eteplirsen, and golodirsen for Duchenne muscular dystrophy: Effectiveness and value: Evidence Report. [ICER DMD-Final-Report\\_081519-2.pdf](#). April 22, 2022. Accessed January 23, 2026.

## Policy History/Revision Information

Date	Summary of Changes
05/01/2026	<p><b>Template Update</b></p> <ul style="list-style-type: none"><li>• Transferred content to shared policy template that applies to both UnitedHealthcare Commercial and Individual Exchange benefit plans</li><li>• Added <i>Application</i> section to indicate this policy applies to:<ul style="list-style-type: none"><li>○ UnitedHealthcare Commercial benefit plans</li><li>○ Individual Exchange benefit plans</li></ul></li></ul> <p><b>Coverage Rationale</b></p> <ul style="list-style-type: none"><li>• Revised coverage criteria; added criterion requiring Vyondys 53 will not be used concomitantly with Duvyzat (givinostat)</li></ul> <p><b>Supporting Information</b></p> <ul style="list-style-type: none"><li>• Updated <i>References</i> section to reflect the most current information</li><li>• Archived previous policy versions 2025D0088H and IEXD0088.09</li></ul>

## Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document

governs. Before using this policy, check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Benefit Drug Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. UnitedHealthcare Medical Benefit Drug Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.