Pharmacy Management Drug Policy

SUBJECT: Encelto (revakinagene taroretcel-lwey) Implant
POLICY NUMBER: PHARMACY-133
EFFECTIVE DATE: 10/2025
LAST REVIEW DATE: 06/12/2026

If the member's subscriber contract excludes coverage for a specific service or prescription drug, it is not covered under that contract. In such cases, medical or drug policy criteria are not applied. This drug policy applies to the following line/s of business:

Policy Application

Category:	☒ Commercial Group (e.g., EPO, HMO, POS, PPO)	☒ Medicare Advantage
	☒ On Exchange Qualified Health Plans (QHP)	☐ Medicare Part D
	☒ Off Exchange Direct Pay	☒ Essential Plan (EP)
	☒ Medicaid & Health and Recovery Plans (MMC/HARP)	☒ Child Health Plus (CHP)
	☐ Federal Employee Program (FEP)	☐ Ancillary Services
	☒ Dual Eligible Special Needs Plan (D-SNP)	

DESCRIPTION:

Macular Telangiectasia (MacTel) Type 2 is a rare, slowly progressive eye disease that affects the macula, the central part of the retina responsible for sharp, detailed vision. It usually affects both eyes, though one may be more severely impacted. Type 2 is the most common form of MacTel and is typically diagnosed in middle age.[1]

In early stages, MacTel Type 2 may have no noticeable symptoms, but it gradually leads to blurred or distorted central vision, difficulty reading, and trouble recognizing faces. Peripheral vision remains intact, and the disease rarely causes total blindness. Symptoms tend to progress over 10 to 20 years.[1]

The condition affects about 0.1% of the population.[2] Risk factors may include smoking, high blood pressure, diabetes, and a possible genetic component, though the exact cause remains unclear.[3] The disease results from abnormal blood vessels around the fovea, which may leak fluid or bleed. In some cases, new abnormal vessels form under the retina, a complication known as macular neovascularization, leading to swelling, scarring, and further vision loss.[2,3]

Diagnosis relies on retinal imaging, including optical coherence tomography (OCT) and fluorescein angiography, along with a clinical evaluation. There are no established treatment guidelines. Management is primarily observational. In cases involving macular neovascularization, anti-VEGF injections may be used, though their effectiveness is often limited.[1-3]

Encelto™ (revakinagene taroretcel-lwey) implant, for intravitreal use

On March 6, 2025, the FDA approved Encelto™, a novel, encapsulated cell-based gene therapy for adults with idiopathic MacTel Type 2.[4] It is the first approved treatment specifically for this condition. Encelto™ delivers recombinant human ciliary neurotrophic factor (rhCNTF), a protein thought to support photoreceptor survival by activating Müller glial cells and triggering protective signaling pathways.[4,5]

Encelto™ was evaluated in two Phase III pivotal, multicenter, double-masked, sham-controlled studies: Study NTMT-03-A (Study 1) and Study NTMT-03-B (Study 2).[5] In both studies, adults with idiopathic Macular Telangiectasia Type 2 (MacTel) were randomized 1:1 to receive either Encelto™ or a sham procedure. The primary endpoint in both trials was the rate of change in the ellipsoid zone (EZ) area loss over 24 months, measured by spectral-domain optical coherence tomography (SD-OCT). Key secondary endpoint was the change in aggregate retinal sensitivity within the EZ break area, measured by microperimetry at 24 months.

Results
Study 1 met its primary endpoint. Encelto™ significantly reduced the rate of EZ area loss (0.075 mm^2 vs. 0.166 mm^2; difference: -0.091 mm^2, $p<0.0001$) compared to sham. A statistically significant smaller loss in retinal sensitivity was also observed in the Encelto™ group (25.27 decibels [dB] vs. 43.02 dB, respectively [P = 0.02]). Study 2 also met its primary endpoint. Encelto™ reduced the rate of EZ area loss (0.111 mm^2 vs. 0.160 mm^2; difference: -0.049 mm^2, $p=0.0186$). However, there was no statistically significant difference in retinal sensitivity loss between groups ($p=0.83$).

Safety
In clinical trials, Encelto™ was associated with several adverse reactions occurring more frequently than in the sham group (Encelto™ vs sham). The most common adverse reactions (incidence ≥2%) included conjunctival hemorrhage (31% vs 26%), delayed dark adaptation (23.1% vs 1%), foreign body sensation (15% vs 13.5%), eye pain (15% vs 9%), suture-related complications (15.4% vs 2.7%), and miosis (15.4% vs 0%).[4]

Other reactions observed more frequently in the Encelto™ group (vs sham) were conjunctival hyperemia (11% vs 8%), eye pruritus (9% vs 3.6%), ocular discomfort (9% vs 1%), vitreous hemorrhage (8.5% vs 0%), blurred vision (7% vs 4%), headache (7% vs 1%), dry eye (6% vs 2%), and eye irritation (5.1% vs 2%). Less common but still more frequent in the Encelto™ group (vs sham) were cataract formation or progression (5% vs 0%), vitreous floaters (5% vs 0%), severe vision loss of more than 15 letters (3% vs 0%), eye discharge (3.4% vs 0.9%), anterior chamber cell (3.4% vs 0%), and iridocyclitis (2.6% vs 0%). Serious adverse reactions occurred in 5% of Encelto™ patients, including suture-related complications and one case of implant extrusion.[4]

RATIONALE:

Encelto™ met its primary endpoints in both Phase III pivotal trials, resulting in a significant reduction in the rate of EZ area loss from baseline over 24 months compared with sham. Slowing the rate of EZ loss has been correlated to photoreceptor preservation.[6-9] Aggregate retinal sensitivity loss, as detected by microperimetry, was observed in both the Encelto and sham groups, but the magnitude of loss was statistically significantly smaller in the Encelto group for Study 1. However, Study 2 did not meet statistical significance in mean change in aggregate retinal sensitivity loss, measure by microperimetry. Therefore, while structural improvement (reduction in EZ area loss) was demonstrated in both studies, the impact of Encelto™ on functional vision (aggregate retinal sensitivity loss) was inconsistent between the two trials.

POLICY:

Encelto (revakinagene taroretcel-lwey)-Medical
Encelto coverage varies by line of business as below: **Commercial/ Essential/Child Health Plus:** 1. Based upon our criteria and assessment of the peer-reviewed evidence, the use of Encelto (revakinagene taroretcel-lwey) has not been medically proven to be effective and, therefore, is considered **not medically necessary** for the treatment of adults with idiopathic macular telangiectasia type 2 (MacTel). The justification for Encelto (revakinagene taroretcel-lwey) to be considered not medically necessary is as follows: a. Based upon our assessment of the peer-reviewed medical literature, there is inconclusive evidence that the drug has a definite positive effect on health outcomes. b. Based upon our assessment of the peer-reviewed medical literature, there is inconclusive evidence that the drug, over time, leads to improvement in health outcomes (e.g., the beneficial effects of the service outweigh any harmful effects). c. Based upon our assessment of the peer-reviewed medical literature, there is inconclusive evidence that the drug provides improvement in health outcomes in standard conditions of medical practice, outside the clinical investigatory settings *Refer to Corporate Medical Policy #11.01.03 Experimental or Investigational Services* **Medicare Advantage/Medicaid/HARP:** 1. Must be 18 years of age or older **AND** 2. Must be prescribed by and administered by an ophthalmologist **AND** 3. Must have a diagnosis of idiopathic macular telangiectasia type 2 (MacTel) **AND** 4. Provider must indicate which eye(s) will be treated **AND** 5. For the eye(s) being treated, the following must be true (a, b, c, and d): a. Must have evidence of fluorescein leakage typical of MacTel on fluorescein angiography **AND** b. Must have at least **one** of the following features (i, ii, iii, iv, or v): i. Hyperpigmentation that is outside of a 500-micron radius from the center of the fovea ii. Retinal opacification iii. Crystalline deposits iv. Right-angle vessels v. Inner/outer lamellar cavities **AND** c. Must have an Inner Segment - Outer Segment (IS/OS) Photo Receptor (PR) break (area of IS/OS loss) in ellipsoid zone (EZ) between 0.16 mm^2 and 2.00 mm^2 as measured by spectral-domain optical coherence tomography (SD-OCT) **AND** d. Must have best corrected visual acuity (BCVA) of 54-letter score or better as measured by the Early Treatment Diabetic Retinopathy Study (ETDRS) chart **OR** have a BCVA of 20/80 or better as measured by the Snellen Chart. i. Documentation within the last 6 months must be provided. **AND** 6. Must not have evidence of intraretinal neovascularization or subretinal neovascularization (SRNV), as evidenced by hemorrhage, hard exudate, subretinal fluid or intraretinal fluid in either eye **AND** 7. Encelto will not be authorized in patients with MacTel type 1 **AND** 8. Encelto will not be authorized for any non-FDA approved indication **AND** 9. Encelto will be limited to a single implant per eye per lifetime. Approval duration will be for 6 months to allow time for procedure to take place.

POLICY GUIDELINES:

1. Utilization Management is contract dependent. Refer to specific contract/benefit language for exclusions.
   a. Coverage criteria may be dependent on the contract renewal date.
   b. Coverage of drugs listed in this policy are contract dependent.
   c. Not all contracts/benefits allow coverage of healthcare professional administered drugs as part of their pharmacy benefit
   d. Not all contracts/benefits cover all medical infusible drugs.
2. Unless otherwise indicated within drug specific criteria, the drugs listed in this policy are administered by a healthcare professional and therefore are covered under the medical benefit.
3. This policy does not apply to Medicare Part D and D-SNP pharmacy benefits. The drugs in this policy may apply to all other lines of business including Medicare Advantage.
4. For members with Medicare Advantage, medications with a National Coverage Determination (NCD) and/or Local Coverage Determination (LCD) will be covered pursuant to the criteria outlined by the NCD and/or LCD. NCDs/LCDs for applicable medications can be found on the CMS website at https://www.cms.gov/medicare-coverage-database/search.aspx. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS permits a Medicare Advantage Organization (MAO) to establish its own coverage determinations in accordance with 42 CFR § 422.101(b)(6). Indications that have not been addressed by the applicable medication's LCD/NCD will be covered in accordance with criteria determined by the Health Plan. Step therapy requirements may be imposed in addition to LCD/NCD requirements.
5. Clinical documentation must be submitted for each request (initial and recertification [if applicable]) unless otherwise specified (e.g., provider attestation required). Supporting documentation includes, but is not limited to, progress notes documenting previous treatments and treatment history, diagnostic testing, laboratory test results, genetic testing or biomarker results, imaging and other objective or subjective measures of clinical benefit.
6. All utilization management requirements outlined in this policy are compliant with applicable New York State insurance laws and regulations. Policies will be reviewed and updated as necessary to ensure ongoing compliance with all state and federally mandated coverage requirements.
7. Manufacturers may either discontinue participation in, or may not participate in, the Medicaid Drug Rebate Program (MDRP). Under New York State Medicaid requirements, physician-administered drugs must be produced by manufacturers that participate in the MDRP. Products made by manufacturers that do not participate in the MDRP will not be covered under Medicaid Managed Care/HARP lines of business. Drug coverage will not be available for any product from a non-participating manufacturer. For a complete list of New/Reinstated & Terminated Labelers please visit: https://www.medicaid.gov/medicaid/prescriptiondrugs/medicaid-drug-rebate-program/newreinstated-terminated-labeler-information/index.html
8. This policy is based on available evidence as of the last review date. Coverage determinations are subject to applicable plan documents, state and federal regulations, and individual patient circumstances. This policy does not constitute medical advice.
9. For commercial contracts, medical necessity determinations align with the Certificate of Coverage issued by the Health Plan, which states that covered services must be clinically appropriate and not primarily for the convenience of the member, the member's family, or the provider.
10. This policy is subject to ongoing revision. Newly marketed drugs and existing drugs with new indications may be subject to prior authorization until formal coverage criteria are established. Inclusion of a drug in this policy does not guarantee its current availability on the market, as some

agents may be discontinued, withdrawn, or otherwise unavailable. As product status changes, drugs may be removed from the policy.

11. The requested site of care may impact approval timeframe and is subject to review.
12. The following applies to all gene and cellular therapies unless otherwise specified within the drug-specific coverage criteria:
    a. Administration, Retreatment, and Treatment with Additional or Other Gene/Cellular Therapies
        i. One-Time Administration
            1. Most gene and cellular therapies, whether autologous, allogeneic ("off-the-shelf"), or in vivo gene-transfer therapies, are designed and studied as one-time treatments.
            2. Repeat dosing, reinfusion, or sequential therapy with other gene or cellular products has not been established as safe, effective, or clinically appropriate.
        ii. Retreatment/Repeat Administration
            1. Retreatment with the same gene or cellular therapy product is considered experimental and investigational because:
                a. Clinical trials evaluated these therapies as single-administration interventions
                b. Safety, efficacy, and durability of a second administration have not been established
                c. Risks immune activation, insertional mutagenesis, or vector immunity may be increased with repeat dosing
        iii. Treatment with an Additional or Other Gene/Cellular Therapy
            1. Treatment with an additional or different gene or cellular therapy after prior exposure to any gene or cellular therapy is currently considered experimental and investigational as there is lack of evidence demonstrating the following (a-c):
                a. Anticipated clinical benefit beyond available standard therapies
                b. Safety of sequential administration
                c. Justification for selecting a second gene/cellular intervention after a prior one
            2. This includes, but is not limited to:
                a. Switching between CAR-T products (e.g., CD19 → CD19 or CD19 → BCMA)
                b. Switching between autologous and allogeneic cellular therapies
                c. Sequential use of CAR-T, TCR-T, NK-cell therapies, or other genetically engineered cell therapies
                d. Receiving a gene therapy after previous gene or cellular therapy exposure
                e. Receiving an in vivo gene therapy following any prior vector-based therapy
        iv. Prior Gene/Cell Therapy Exposure
            1. An is generally not eligible for additional gene or cellular therapy if they have previously received:
                a. Any autologous cellular therapy (e.g., CAR-T, TCR-T, TIL),
                b. Any allogeneic genetically modified cellular therapy,
                c. Any in vivo gene therapy (e.g., AAV, lentiviral vector)
                d. Any ex vivo gene-modified cell product
                e. Are being considered for any other gene or cellular therapy without documented evidence supporting safety and anticipated benefit.

CODES:

Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract.
CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.

Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.

Code Key:
Experimental/Investigational = (E/I),
Not medically necessary/ appropriate = (NMN).

HCPCS: J3403

UPDATES:

Date	Revision
06/12/2026	Revised
01/01/2026	Revised
11/19/2025	Revised
10/01/2025	Created and Implemented
08/14/2025	P&T Committee Approval

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