Clinical Policy: Veligrotug (VRDN-001)

Reference Number: CP.PHAR.773
Effective Date: FDA Approval Date
Last Review Date: 05.26
Line of Business: Commercial, HIM-Medical Benefit/ICHRA*, Medicaid

Coding Implications
Revision Log

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

Description

Veligrotug (VRDN-001) is an insulin-like growth factor 1 receptor (IGF-1R) inhibitor.

**For Health Insurance Marketplace (HIM)/ICHRA, coverage of VRDN-001 is excluded for the pharmacy benefit and should not be approved using these criteria; these criteria may be used for medical benefit review.*

FDA Approved Indication(s) [Pending]

VRDN-001 is indicated for the treatment of thyroid eye disease (TED) regardless of TED activity or duration.

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.

It is the policy of health plans affiliated with Centene Corporation® that VRDN-001 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. Thyroid Eye Disease (must meet all)**:**

1. Diagnosis of Graves' disease with associated TED (i.e., Graves' ophthalmopathy, Graves' orbitopathy);
2. Prescribed by or in consultation with an ophthalmologist;
3. One of the following (a or b):
   a. Member is euthyroid with documentation of a recent (within the last 30 days) free thyroxine (FT4) and total triiodothyronine (T3) or free T3 (FT3) levels within the laboratory defined reference range;
   b. Member has a recent (within the last 30 days) free thyroxine (FT4) and total triiodothyronine (T3) or free T3 (FT3) levels less than 50% above or below the laboratory defined reference range and is undergoing treatment to correct the mild hypo- or hyperthyroidism to maintain a euthyroid state;
4. Member has not had previous surgical intervention for TED;
5. Member does not require surgical ophthalmological intervention;
6. Failure of a 4-week trial of a systemic corticosteroid (at up to maximally indicated doses), unless one of the following (a, b, or c):*
   **For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*

a. Clinically significant adverse effects are experienced or all are contraindicated;
b. Member has significant proptosis (examples may include but are not limited to proptosis ≥ 3 mm above the upper limit for race and sex, or proptosis that impacts activities of daily life [e.g., reading, driving, computer work, and watching television]);
c. Member has diplopia;

7. VRDN-001 is not prescribed concurrently with Tepezza™;
8. Member has not received ≥ 5 VRDN-001 infusions;
9. Dose does not exceed a total of five 600 mg infusions given every 3 weeks.

Approval duration: 6 months (up to 5 total lifetime infusions)

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, HIM-Medical Benefit /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, HIM-Medical Benefit/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for HIM-Medical Benefit/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 HIM-Medical Benefit/ICHRA, and CP.PMN.53 for Medicaid.

II. Continued Therapy*

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

A. Thyroid Eye Disease (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member has not had previous surgical intervention for TED;
3. Member does not require surgical ophthalmological intervention;
4. VRDN-001 is not prescribed concurrently with Tepezza™;
5. Member has not received ≥ 5 VRDN-001 infusions;
6. If request is for a dose increase, new dose does not exceed five 600 mg infusions given every 3 weeks.

Approval duration: 1 month (up to 5 total lifetime infusions)

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, HIM-Medical Benefit/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for HIM-Medical Benefit/ICHRA , and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, HIM-Medical Benefit/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for HIM-Medical Benefit/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 HIM-Medical Benefit/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 HIM-Medical Benefit/ICHRA, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CAS: clinical activity score
FDA: Food and Drug Administration
GO: Graves' ophthalmopathy
IGF-1R: insulin-like growth factor 1 receptor
TED: thyroid eye disease

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	30 mg/day PO	30 mg/day
methylprednisolone (SOLU-Medrol®)	500 mg IV once weekly for weeks 1 to 6, then 250 mg IV once weekly for weeks 7-12	500 mg/week

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.

Appendix C: Contraindications/Boxed Warnings [Pending]

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

Appendix D: General Information

- Use of systemic corticosteroids in TED is supported by the following treatment guidelines:
  - 2021 European Group on Graves' orbitopathy (EUGOGO) clinical practice guidelines for the medical management of Graves' orbitopathy: A combination of IV methylprednisolone and mycophenolate sodium is recommended as first-line treatment. If response to primary treatment is poor and Graves' ophthalmopathy (GO) is still moderate-to-severe and active, teprotumumab is considered a second-line option as longer-term data, availability, affordability, costs, and need for subsequent rehabilitative surgery are pending.
  - 2016 American Thyroid Association Guidelines for Diagnosis and Management of Hyperthyroidism and Other Causes of Thyrotoxicosis: In the absence of any strong contraindication to GC, consider for coverage of mild active GO who are treated with RAI, even in the absence of risk factors for GO deterioration (weak recommendation, low-quality evidence). Additionally in mild GO patients who are treated with RAI, steroid coverage is recommended if there are concomitant risk factors for GO deterioration (strong recommendation, moderate-quality evidence).
  - 2022 American Thyroid Association Consensus Statement on the Management of Thyroid Eye Disease: Intravenous glucocorticoid therapy is a preferred treatment for active moderate-to-severe TED when disease activity is the prominent feature in the absence of either significant proptosis or diplopia.

V. Dosage and Administration [Pending]

Indication	Dosing Regimen	Maximum Dose
TED	600 mg IV every 3 weeks for five infusions	See dosing regimen

VI. Product Availability [Pending]

Single-dose vial: 500 mg

VII. References

1. NCT05176639 in ClinicalTrials.gov. A safety, tolerability and efficacy study of veligrotug (VRDN 001) in healthy volunteers and participants with thyroid eye disease (TED) (THRIVE) (THRIVE). NIH U.S. National Library of Medicine. Available at: https://clinicaltrials.gov/study/NCT05176639. Accessed January 20, 2026.
2. NCT06021054 in ClinicalTrials.gov. An efficacy, safety, and tolerability study of veligrotug (VRDN-001), in participants with chronic thyroid eye disease (TED) (THRIVE-2) (THRIVE-2). NIH U.S. National Library of Medicine. Available at: https://clinicaltrials.gov/study/NCT05176639. Accessed January 20, 2026.
3. Viridian Therapeutics announces positive long-term durability data from the veligrotug phase 3 THRIVE clinical trial in patients with active thyroid eye disease (TED). News release. Viridian Therapeutics, Inc. May 20, 2025. Available at: https://investors.viridiantherapeutics.com/news/news-details/2025/Viridian-Therapeutics-Announces-Positive-Long-Term-Durability-Data-from-the-Veligrotug-Phase-3-THRIVE-Clinical-Trial-in-Patients-with-Active-Thyroid-Eye-Disease-TED/default.aspx. Accessed January 21, 2026.

4. Viridian Therapeutics announces positive topline results from veligrotug (VRDN-001) phase 3 THRIVE clinical trial in patients with active thyroid eye disease. Press Release; September 10, 2024. Available at: https://investors.viridiantherapeutics.com/news/news-details/2024/Viridian-Therapeutics-Announces-Positive-Topline-Results-from-Veligrotug-VRDN-001-Phase-3-THRIVE-Clinical-Trial-in-Patients-with-Active-Thyroid-Eye-Disease/default.aspx. Accessed January 21, 2026.
5. Ross DS, Burch HB, Cooper DS, et al. 2016 American Thyroid Association Guidelines for diagnosis and management of hyperthyroidism and other causes of thyrotoxicosis. Thyroid 2016; 26:1343.
6. Mourits MP, Prummel MF, Wiersinga WM, Koornneef L. Clinical activity score as a guide in the management of patients with Graves' ophthalmopathy. Clin Endocrinol (Oxf) 1997; 47:9.
7. Patel KN, Yip L, Lubitz CC, et al. The American Association of Endocrine Surgeons Guidelines for the definitive surgical management of thyroid disease in adults. Annals of Surgery: March 2020; 271 (3): e21-e93.
8. Bartalena L, Kahaly GJ, Baldeschi L, et al. The 2021 European Group on Graves' orbitopathy (EUGOGO) clinical practice guidelines for the medical management of Graves' orbitopathy. European Journal of Endocrinology: 27 August 2021; 185 (4): G43-G67.
9. Burch HB, Perros P, Bednarczuk T, et al. Management of Thyroid Eye Disease: A Consensus Statement by the American Thyroid Association and the European Thyroid Association. Thyroid: 12 Dec 2022. 32 (12): 1439-1470.

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.	02.24.26	05.26

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.