GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
ENZYME REPLACEMENT, GAUCHERS DISEASE PA SUMMARY

Preferred	Non-Preferred
Cerdelga (eliglustat) Cerezyme (imiglucerase) Elelyso (taliglucerase alfa) VPRIV (velaglucerase alfa) Zavesca (miglustat)*	n/a

*Does not require PA.

LENGTH OF AUTHORIZATION: 1 year

NOTE:

- If the medication is being administration in a physician's office or clinic, please go to the Registered User portion of the Georgia Health Partnership website at www.mmis.georgia.gov/portal to request coverage from Physician Services.

PA CRITERIA:

Cerdelga

- Approvable for members 18 years of age or older with a diagnosis of Type 1 Gaucher Disease who are CYP2D6 extensive metabolizers, intermediate metabolizers or poor metabolizers and member must have severe Gaucher Disease (platelet count <60,000/microL, liver >2.5 times normal size, spleen >15 times normal size, radiologic evidence of skeletal disease).

Cerezyme

- Approvable for members with a diagnosis of Type 1 Gaucher Disease.
- For members 17 years of age or younger, member must have symptomatic Gaucher Disease (malnutrition, growth retardation, impaired psychomotor development and/or fatigue).
- For members 18 years of age or older, member must have severe Gaucher Disease (platelet count <60,000/microL, liver >2.5 times normal size, spleen >15 times normal size, radiologic evidence of skeletal disease) and must have tried and failed Elelyso or VPRIV.
- Member must have received at least 3 prior infusions in a hospital or clinic setting.
- Medication must be administered in member's home by home health or in a long-term care facility.

Elelyso and VPRIV

- Approvable for members 4 years of age or older with a diagnosis of Type 1 Gaucher Disease.
- For members 4-17 years of age, member must have symptomatic Gaucher Disease (malnutrition, growth retardation, impaired psychomotor development and/or fatigue).

- For members 18 years of age or older, member must have severe Gaucher Disease (platelet count <60,000/microL, liver >2.5 times normal size, spleen >15 times normal size, radiologic evidence of skeletal disease).
- Member must have received at least 3 prior infusions in a hospital or clinic setting.
- Medication must be administered in member's home by home health or in a long-term care facility.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827.**

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

PA and APPEAL PROCESS:

- For online access to the PA process, please go to http://dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the Quantity Level Limits (QLL), please go to https://www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.