

## ENZYMES FOR GAUCHER DISEASE PA SUMMARY

<b>PREFERRED</b>	Cerdelga (eliglustat) Cerezyme (imiglucerase), Elelyso (taliglucerase), VPRIV (velaglucerase), Zavesca (miglustat)*
<b>NON-PREFERRED</b>	n/a

\*Does not require PA.

**STATUS:** Preferred

**LENGTH OF AUTHORIZATION:** 1 Year

**NOTE:**

- ❖ Physicians administering Cerezyme, Elelyso or VPRIV in the office must bill the drug through the DCH physician's injectable program and not the outpatient pharmacy program. Go to the Registered User portion of the Georgia Health Partnership website for information regarding the physician's injectable program is located at [www.mmis.georgia.gov](http://www.mmis.georgia.gov).

**PA CRITERIA:**

*For Cerdelga*

- ❖ Approvable for Type 1 Gaucher Disease in members 18 years of age or older who are CYP2D6 extensive metabolizers, intermediate metabolizers or poor metabolizers.
- ❖ 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 not have pre-existing cardiac disease or long QT syndrome, or take Cerdelga concomitantly with enzyme replacement therapy (ERT; Cerezyme, Elelyso, VPRIV).

*For Cerezyme*

- ❖ Medication must be administered in member's home by home health or in a long-term care facility.
- ❖ Approvable for 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).
- ❖ For members 18 years of age or older, member must have tried and failed Elelyso or VPRIV.
- ❖ Member must have received at least 3 prior infusions in a hospital or clinic setting.

*For Elelyso and VPRIV*

- ❖ Medication must be administered in member's home by home health or in a long-term care facility.

- ❖ Approvable for Type 1 Gaucher Disease in members 4 years of age or older.
- ❖ 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.

**EXCEPTIONS:**

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

**PA and APPEAL PROCESS:**

- ❖ For online access to the PA process, please go to [www.dch.georgia.gov/prior-authorization-process-and-criteria](http://www.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 current Quantity Level Limits (QLL), please go to [www.mmis.georgia.gov/portal](http://www.mmis.georgia.gov/portal), highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.