



**GEORGIA MEDICAID FEE-FOR-SERVICE  
FABRY DISEASE AGENTS PA SUMMARY**

<b>Preferred</b>	<b>Non-Preferred</b>
Galafold (migalastat)	n/a

**LENGTH OF AUTHORIZATION:** 6 months

**PA CRITERIA:**

- ❖ Approvable for members 18 years of age or older with a diagnosis of Fabry disease who have an amenable galactosidase alpha gene (*GLA*) variant based on in vitro assay data.

**EXCEPTIONS:**

- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process 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 [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.