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

<table>
<thead>
<tr>
<th>Preferred</th>
<th>Non-Preferred</th>
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<tbody>
<tr>
<td>Galafold (migalastat)</td>
<td>N/A</td>
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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 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, highlight Pharmacy and click on Other Documents, then select the most recent quarters QLL List.