

## **Clinical Policy: Eliglustat (Cerdelga)**

Reference Number: CP.PHAR.153

Effective Date: 02.01.16

Last Review Date: 05.23

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Eliglustat (Cerdelga<sup>®</sup>) is a glucosylceramide synthase inhibitor.

### **FDA Approved Indication(s)**

Cerdelga is indicated for the long-term treatment of adult patients with type 1 Gaucher disease (GD1) who are CYP2D6 extensive metabolizers, intermediate metabolizers, or poor metabolizers as detected by an FDA-cleared test.

Limitation(s) of use:

- CYP2D6 ultra-rapid metabolizers may not achieve adequate concentrations of Cerdelga to achieve a therapeutic effect.
- A specific dosage cannot be recommended for CYP2D6 indeterminate metabolizers.

### **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<sup>®</sup> that Cerdelga is **medically necessary** when the following criteria are met:

#### **I. Initial Approval Criteria**

##### **A. Type 1 Gaucher Disease** (must meet all):

1. Diagnosis of GD1 confirmed by one of the following (a or b):
  - a. Enzyme assay demonstrating a deficiency of beta-glucocerebrosidase (glucosidase) activity;
  - b. DNA testing;
2. Age  $\geq$  18 years;
3. Member is symptomatic (e.g., anemia, thrombocytopenia, bone disease, hepatomegaly, splenomegaly);
4. Member is positive for one of the following CYP2D6 genotypes as detected by an FDA-cleared test (a, b, or c):
  - a. Extensive metabolizer (EM);
  - b. Intermediate metabolizer (IM);
  - c. Poor metabolizer (PM);
5. Cerdelga is prescribed as monotherapy;

6. Dose does not exceed:
  - a. CYP2D6 EMs and IMs (both i and ii):
    - i. 168 mg per day;
    - ii. 2 capsules per day;
  - b. CYP2D6 PMs (both i and ii):
    - i. 84 mg per day;
    - ii. 1 capsule per day.

**Approval duration: 6 months**

**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, health insurance marketplace) 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, and CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, 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 health insurance marketplace, and CP.PMN.53 for Medicaid.

**II. Continued Therapy**

**A. Type 1 Gaucher 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 is responding positively to therapy as evidenced by increased or stabilized platelet count or hemoglobin level, reduced or stabilized spleen or liver volume, or decreased bone pain;
3. Cerdelga is prescribed as monotherapy;
4. If request is for a dose increase, new dose does not exceed:
  - a. CYP2D6 EMs and IMs (both i and ii):
    - i. 168 mg per day;
    - ii. 2 capsules per day;
  - b. CYP2D6 PMs (both i and ii):
    - i. 84 mg per day;
    - ii. 1 capsule per day.

**Approval duration: 12 months**

**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, health insurance marketplace) 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, and CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, 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 health insurance marketplace, 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 health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

EM: extensive metabolizer

IM: intermediate metabolizer

FDA: Food and Drug Administration

PM: poor metabolizer

GD1: type 1 Gaucher disease

*Appendix B: Therapeutic Alternatives*

Not applicable

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s):
  - For EMs – taking a strong or moderate CYP2D6 inhibitor concomitantly with a strong or moderate CYP3A inhibitor; moderate or severe hepatic impairment; mild hepatic impairment taking a strong or moderate CYP2D6 inhibitor
  - For IMs – taking a strong or moderate CYP2D6 inhibitor concomitantly with a strong or moderate CYP3A inhibitor; taking a strong CYP3A inhibitor; any degree of hepatic impairment
  - For PMs – taking a strong CYP3A inhibitor; any degree of hepatic impairment
- Boxed warning(s): none reported

*Appendix D: General Information*

- GD1 is a heterogeneous disorder which involves the visceral organs, bone marrow, and bone in almost all affected patients. Common conditions resulting from GD1 include anemia, thrombocytopenia, hepatomegaly, splenomegaly, and bone disease. Therefore, hemoglobin level, platelet count, liver volume, spleen volume, and bone pain are clinical parameters that can indicate therapeutic response to GD1 therapies. In some clinical trials, stability has been defined as the following thresholds of change from baseline: hemoglobin level < 1.5 g/dL decrease, platelet count < 25% decrease, liver volume < 20% increase, and spleen volume < 25% increase.
- There is currently insufficient evidence that supports the combination use of enzyme replacement therapy with Cerdelga.
- A specific dosage cannot be recommended for those patients whose CYP2D6 genotype cannot be determined (indeterminate metabolizers).

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
GD1	CYP2D6 EM, IM: 84 mg PO BID CYP2D6 PM: 84 mg PO QD	CYP2D6 EM, IM: 168 mg/day CYP2D6 PM: 84 mg/day

**VI. Product Availability**

Capsule: 84 mg

**VII. References**

1. Cerdelga Prescribing Information. Waterford, Ireland: Genzyme Ireland, Ltd.; December 2022. Available at <http://www.cerdelga.com>. Accessed February 7, 2023.
2. Charrow J, Andersson HC, Kaplan P. Enzyme replacement therapy and monitoring for children with type 1 Gaucher disease: consensus recommendations. *J Pediatr*. 2004;144: 112-20.
3. Hollak, CEM, Weinreb NJ. The attenuated/late onset lysosomal storage disorders: therapeutic goals and indications for enzyme replacement treatment in Gaucher and Fabry disease. *Best Pract Res Clin Endocrinol Metab*. 2015;29:205-218.
4. Pastores GM, Weinreb NJ, Aerts H, et al. Therapeutic goals in the treatment of Gaucher disease. *Semin Hematol*. 2004;41(suppl 5):4-14.
5. Andersson HC, Charrow J, Kaplan P, et al. Individualization of long-term enzyme replacement therapy for Gaucher disease. *Genet Med*. 2005;7(2):105-110.
6. Balwani M, Burrow TA, Charrow J, et al. Recommendations for the use of eliglustat in the treatment of adults with Gaucher disease type 1 in the United States. *Molecular Genetics and Metabolism*. 2016;117(2):95-103.
7. Gary SE, Ryan E, Steward AM, et al. Recent advances in the diagnosis and management of Gaucher disease. *Expert Rev Endocrinol Metab*. 2018 Mar;13(2):107–118.
8. Leonart LP, Fachi MM, Boger B, et al. A systematic review and meta-analyses of longitudinal studies on drug treatments for Gaucher disease. *Ann Pharmacother*. 2022;0(0). doi:10.1177/10600280221108443.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2019 annual review: no significant changes; references reviewed and updated.	02.27.19	05.19
2Q 2020 annual review: no significant changes; references reviewed and updated.	02.05.20	05.20
2Q 2021 annual review: no significant changes; revised HIM.PHAR.21 to HIM.PA.154; references reviewed and updated.	02.27.21	05.21
2Q 2022 annual review: no significant changes; references reviewed and updated.	02.23.22	05.22
Template changes applied to other diagnoses/indications and continued therapy section.	09.30.22	
2Q 2023 annual review: no significant changes; references reviewed and updated.	02.07.23	05.23

**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.

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**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.

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