Clinical Policy: Gaucher Disease Therapy – Enzyme Replacement
Reference Number: CP.CPA.241
Effective Date: 11.16.16
Last Review Date: 11.17
Line of Business: Commercial

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
The following are intravenous enzyme replacement drugs for the treatment of Gaucher disease requiring prior authorization: imiglucerase (Cerezyme®), velaglucerase (VPRIV™), taliglucerase (Elelyso™)

FDA approved indication
Cerezyme is indicated as long-term enzyme replacement therapy for pediatric and adult patients with a confirmed diagnosis of Type I Gaucher disease that results in one or more of the following conditions:
- Anemia
- Thrombocytopenia
- Bone disease
- Hepatomegaly or splenomegaly

VPRIV is indicated as long-term enzyme replacement therapy (ERT) for patients with Type I Gaucher disease.

Elelyso is indicated for the treatment of patients with a confirmed diagnosis of Type I Gaucher disease.

Policy/Criteria
Provider must submit documentation (which may include office chart notes and lab results) supporting that member has met all approval criteria

It is the policy of health plans affiliated with Centene Corporation® that Cerezyme, VPRIV, Elelyso are medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Gaucher Disease (must meet all):
      1. Diagnosis of Type 1 or Type 3 Gaucher disease;
      2. Diagnosis is confirmed by measurement of beta-glucocerebrosidase activity (in leukocytes or skin fibroblasts) of less than 30% of normal values OR deoxyribonucleic acid (DNA) testing (mutations in the glucocerebrosidase gene);
      3. Patient exhibits clinical signs and symptoms of the disease, including anemia, thrombocytopenia, skeletal disease, or visceromegaly (liver or spleen enlargement);
      4. Dose does not exceed 60 units/kg every other week.

   Approval duration: Length of benefit
B. Other diagnoses/indications
   1. Refer to CP.CPA.09 if diagnosis is NOT specifically listed under section III
      (Diagnoses/Indications for which coverage is NOT authorized)

II. Continued Therapy
   A. Type 1 Gaucher Disease (must meet all):
      1. Currently receiving medication via a health plan affiliated with Centene Corporation
         or member has previously met initial approval criteria;
      2. Member is responding positively to therapy;
      3. If request is for a dose increase, new dose does not exceed 60 units/kg every other
         week.
      Approval duration: Length of benefit

   B. Other diagnoses/indications (must meet 1 or 2):
      1. Currently receiving medication via a health plan affiliated with Centene Corporation
         and documentation supports positive response to therapy.
         Approval duration: Duration of request or 12 months (whichever is less); or
      2. Refer to CP.CPA.09 if diagnosis is NOT specifically listed under section
         (Diagnoses/Indications for which coverage is NOT authorized)

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 policy –
      CP.CPA.09 or evidence of coverage documents

IV. Appendices/General Information
   Appendix A: Abbreviation/Acronym Key
   ERT: Enzyme replacement therapy

   Appendix B: General Information
   • Physicians must complete and sign the Start Form (VPRIV Prescription and OnePathSM
     Start Form) as well as the Statement of Medical Necessity form. Call a OnePathSM Case
     Manager at 1-866-888-0660 to access the necessary forms.
   • Enzyme replacement therapy may have beneficial palliative effects in Type 2 disease, but
     does not alter the outcome and is not generally used.
   • According to the European consensus guidelines revised recommendations on the
     management of neuronopathic Gaucher disease by Vellodi et al: (1) there is clear
     evidence in most patients that enzyme replacement therapy (ERT) ameliorates systemic
     involvement in non-neuronopathic (Type 1) as well as chronic neuronopathic Gaucher
     disease (Type 3), enhancing quality of life; (2) There is no evidence that ERT has
     reversed, stabilized or slowed the progression of neurological involvement; (3) In patients
     with established acute neuronopathic Gaucher disease (Type 2), enzyme replacement
     therapy has had little effect on the progressively downhill course. It has merely resulted
     in prolongation of pain and suffering.
In a study by Altarescu et al, enzyme replacement therapy with Ceredase/Cerezyme reversed the systemic manifestations (hemoglobin levels, platelet counts, liver and spleen volumes) in 19 patients with type 3 Gaucher disease. There was no evidence that improvement in the systemic disease manifestations led to early cognitive improvement or altered the neurologic course. Doses of Ceredase/Cerezyme used ranged from 120 unit/kg – 480 units/kg per month with the average being 120 units/kg every 2 weeks.

There is currently insufficient clinical evidence that supports the combination use of enzyme replacement therapy with Zavesca® (miglustat).

Appendix C: Therapeutic Alternatives

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Drug</th>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cerezyme</td>
<td>Type 1 or type 3 Gaucher Disease</td>
<td>2.5 units/kg via IV infusion 3 times weekly to 60 units/kg once every 2 weeks</td>
<td>60 units/kg every other week</td>
</tr>
<tr>
<td>VPRIV</td>
<td>Type 1 or type 3 Gaucher Disease</td>
<td>60 units/kg via IV infusion every other week</td>
<td>60 units/kg every other week</td>
</tr>
<tr>
<td>Elelyso</td>
<td>Type 1 or type 3 Gaucher disease</td>
<td>60 units/kg via IV infusion every other week</td>
<td>60 units/kg every other week</td>
</tr>
</tbody>
</table>

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

VI. Product Availability

<table>
<thead>
<tr>
<th>Drug</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cerezyme</td>
<td>200 units and 400 units per vial</td>
</tr>
<tr>
<td>VPRIV</td>
<td>400 units per vial</td>
</tr>
<tr>
<td>Elelyso</td>
<td>200 units per vial</td>
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</table>

VII. References


<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Converted to new template. Minor changes to verbiage and grammar. References updated.</td>
<td>06.10.17</td>
<td>11.17</td>
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**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.

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