MEDICAL POLICY STATEMENT		
Original Effective Date	**Next Annual Review Date**	**Last Review / Revision Date**
06/15/2011	**03/15/2017**	**10/04/2016**
Policy Name		**Policy Number**
Enzyme Replacement Therapy		**SRx-0019**
Policy Type		
☒ **Medical**	☐ **Administrative**	☐ **Payment**

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

For Medicare plans please reference the below link to search for Applicable National Coverage Descriptions (NCD) and Local Coverage Descriptions (LCD):

A. SUBJECT

Enzyme Replacement Therapy and Agents

- agalsidase beta (Fabrazyme)
- alglucosidase alfa (Lumizyme)
- elosulfase alfa (Vimizim)
- galsulfase (Naglazyme)
- idursulfase (Elaprase)
- imiglucerase (Cerezyme)
- laronidase (Aldurazyme)
- taliglucerase alfa (Elelyso)
- velaglucerase alfa (Vpriv)

B. BACKGROUND

CareSource medication policies are therapy class policies that are used as a guide when determining health care coverage for our members with benefit plans covering prescription drugs requiring prior authorization or Step-Therapy. The medication policy is used as a tool to be interpreted in conjunction with the member's specific benefit plan.

The intent of the enzyme replacement agent's medication (PA) program is to encourage appropriate selection of patients for therapy according to product labeling and/or clinical guidelines and/or clinical studies, and also to encourage use of preferred agents.

C. DEFINITIONS

N/A

D. POLICY

I. CareSource will approve the use of **agalsidase beta (Fabrazyme)** and consider its use as medically necessary when the **ALL** of the following criteria have been met:

A. Diagnosis of Fabry disease (FD) documented and confirmed by enzyme assay showing deficiency of alpha-galactosidase enzyme activity or by DNA testing. *Attach lab results and/or documentation.*

1. For **male patients age 16 and older with or without symptoms or clinical signs of organ involvement** if diagnosed with classical FD as defined by the present of a GLA mutation, absent or very low residual enzyme activity, and the presence of one of the following: angiokeratoma, cornea verticillata, or a very high (lyso) Gb3 level. *Include lab results and documentation.*
2. For **all other patients** (males with non-classical FD, females with classical FD or non-classical FD**)**, if age 8 years or older and clinical signs or organ involvement consistent with FD as indicated by **one or more** of the following:
    a. Renal involvement – microalbuminuria, proteinuria, renal insufficiency (GFR ≤ 90 mL/min/1.73m^2.
    b. Cardiac involvement – cardiac hypertrophy (maximal wall thickness (MWT) > 12 mm) with no or minimal signs of fibrosis or conduction abnormalities
    c. CNS involvement – white matter lesions (WMLs), history of TIA or stroke, or hearing loss corrected for age, neuropathic pain in hands and/or feet that started before age 18 years or increasing with heat or fever
    d. Gastrointestinal involvement – chronic, severe abdominal pain or diarrhea not due to another etiology

B. Prescribed by or under the recommendation of a geneticist or under the care of a physician with expertise in Fabry Disease

II. CareSource will approve the use of **alglucosidase alfa (Lumizyme)** and consider its use as medically necessary when **ALL** of the following criteria have been met:

A. Prescribed by or under the recommendation of a geneticist or under the care of a physician with expertise in Pompe disease

B. Plus, **one** of the following:

1. Diagnosis of infantile early-onset form of Pompe disease as documented and confirmed by enzyme assay showing deficiency in acid alpha-glucosidase (GAA), DNA testing, or muscle biopsy. *Include lab results and documentation.*

2. Diagnosis of non-infantile, late-onset Pompe disease as documented and confirmed by enzyme assay showing deficiency in acid alpha-glucosidase (GAA), DNA testing, or muscle biopsy plus **one or more** of the following:

    a. Onset of or presence of symptoms of Pompe disease as documented in chart notes
    b. Onset of, presence of, or increased proximal muscle weakness
    c. Reduced forced vital capacity in upright or supine position

III. CareSource will approve the use of **elosulfase alfa (Vimizim)** and consider its use as medically necessary when **ALL** of the following criteria have been met:

A. Diagnosis of mucopolysaccharidosis IVA (MPS IVA) (Morquio A Syndrome) as documented and confirmed by enzyme assay showing a deficiency in N-acteylgalactosamine 6-sulfatase or DNA testing. *Include lab results and documentation.*
B. Prescribed by or under the recommendation of a geneticist or under the care of a physician with expertise in MPS IVA
C. Patient must be 5 years of age or older

IV. CareSource will approve the use of **galsulfase (Naglazyme)** and consider its use as medically necessary when **ALL** of the following criteria have been met:
A. Diagnosis of mucopolysaccharidosis VI (MPS VI) (Maroteaux-Lamy Syndrome) as documented and confirmed by enzyme assay showing deficiency in arylsulfatase B or DNA testing. *Include lab results and documentation.*
B. Prescribed by or under the recommendation of a geneticist or under the care of a physician with expertise in MPS VI (Maroteaux-Lamy syndrome).
C. The patient is at least 3 months old.

V. CareSource will approve the use of **idursulfase (Elaprase)** and consider its use as medically necessary when the **ALL** of the following criteria have been met:
A. Diagnosis of mucopolysaccharidosis II (MPS II) or Hunter syndrome documented and confirmed by enzyme assay demonstrating a deficiency of iduronate 2-sulfatase enzyme activity or by DNA testing. *Include lab results and/or documentation.*
B. Prescribed by or under the recommendation of a geneticist or under the care of a physician with expertise in MPS II or Hunter syndrome
C. The patient is 5 years and older

VI. CareSource will approve the use of **imiglucerase (Cerezyme), taliglucerase alfa (Elelyso), or velaglucerase (Vpriv)** and consider its use as medically necessary when the **ALL** of the following criteria have been met:
A. Diagnosis of non-neuropathic type 1 Gaucher disease documented and confirmed by enzyme assay identifying reduced glucocerebrosidase activity or DNA testing. *Include lab results and/or documentation.*
B. Prescribed by or under the recommendation of a geneticist or hematologist, or under care of physician with expertise in Gaucher disease.
C. Patient must be:
1. 2 years of age and older for use of imiglucerase (Cerezyme)
2. 4 years of age and older for use of taliglucerase alfa (Elelyso)
3. 4 years of age and older for use of velaglucerase (Vpriv)
D. Symptomatic disease defined by presence of:
1. **One or more** of the following in **children** documented in chart notes: malnutrition, growth retardation, impaired psychomotor development and/or fatigue.
2. **One or more** of the following in **adults:** Anemia (hemoglobin <8 g/dL), thrombocytopenia (platelet count <120,000/mm^3), hepatomegaly (liver > 2.5 times normal size), splenomegaly (spleen > 15 times normal size), or bone disease (chronic bone pain, acute bone crises, bone fractures, osteopenia, osteonecrosis, osteolysis, osteosclerosis, kyphosis).

VII. CareSource will approve the use of **laronidase (Aldurazyme)** and consider its use medically necessary when **ALL** of the following criteria have been met:
A. Diagnosis of Hurler and Hurler-Scheie forms of mucopolysaccharidosis (MPS I) and for patients with the Scheie form who have moderate to severe symptoms documented and

confirmed by an enzyme assay demonstrating a deficiency of alpha-L-iduronidase enzyme activity or by DNA testing. *Include lab results and/or documentation.*

B. Prescribed by or under the recommendation of a geneticist or under care of a physician with expertise in MPS I
C. The patient is 6 months and older

All other uses of agalsidase beta, alglucosidase alfa, elosulfase alfa, galsulfase, idursulfase, imiglucerase, laronidase, taliglucerase alfa, velaglucerase alfa are considered experimental/investigational; and therefore, will follow CareSource's Off-Label policy.

Note: Documented diagnosis must be confirmed by portions of the individual's medical record which will confirm the presence of disease and will need to be supplied with prior authorization request. These medical records may include, but not limited to test reports, chart notes from provider's office or hospital admission notes.

CONDITIONS OF COVERAGE

HCPCS	J0180	Fabrazyme (agalsidase beta)
	J0220	Lumizyme (alglucosidase alfa)
	C9022	Vimizim (elosulfase alfa)
	J1458	Naglazyme (galsulfase)
	J1743	Elaprase (idursulfase)
	J1786	Cerezyme (imiglucerase)
	J1931	Aldurazyme (laronidase)
	J3060	Elelyso (taliglucerase alfa)
	J3385	Vpriv (velaglucerase alfa)

CPT

PLACE OF SERVICE
Office, Outpatient, Home
Note: CareSource supports administering inject able medications in various setting, as long as those services are furnished in the most appropriate and cost effective setting that are supportive of the patient's medical condition and unique needs and condition. The decision on the most appropriate setting for administration is based on the member's current medical condition and any required monitoring or additional services that may coincide with the delivery of the specific medication.

AUTHORIZATION PERIOD
Approved initial authorizations are valid for three months. Continued treatment may be considered when the member has shown biological response to treatment. A reauthorization after successful initiation period will be placed for one year. **ALL** authorizations are subject to continued eligibility.

E. REVIEW/REVISION HISTORY

Date Issued: 06/15/2011
Date Revised: 12/15/2014 – removed Ceredase & added Elelyso
02/15/2015 – placed into new template
11/17/2015 – updated and revised to add corneal clouding or glaucoma; add high frequency hearing impairment.
10/04/2016 – Removed eliglustat and miglustat, updated criteria for all agents on policy, updated references.

F. REFERENCES

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The Medical Policy Statement detailed above has received due consideration as defined in the Medical Policy Statement Policy and is approved.