SPECIALTY GUIDELINE MANAGEMENT

VPRIV (velaglucerase alfa)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

VPRIV is indicated for long-term enzyme replacement therapy (ERT) for patients with type 1 Gaucher disease.

II. CRITERIA FOR INITIAL APPROVAL

Gaucher disease type 1

Indefinite authorization may be granted for treatment of Gaucher disease type 1 when the diagnosis of Gaucher disease was confirmed by enzyme assay demonstrating a deficiency of beta-glucocerebrosidase (glucosidase) enzyme activity or by genetic testing.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. VPRIV [package insert]. Lexington, MA: Shire Human Genetic Therapies, Inc.; April 2015.
2. Pastores GM, Hughes DA. Gaucher Disease. [Updated February 26, 2015]. In: Pagon RA, Adam MP, Ardinger HH, et al, editors. GeneReviews® [Internet]. Seattle, WA: University of Washington, Seattle; 1993-2016.
3. Kaplan P, Baris H, De Meirleir L, et al. Revised recommendations for the management of Gaucher disease in children. *Eur J Pediatr.* 2013;172:447-458.