PHARMACY POLICY STATEMENT **Georgia Medicaid**	
DRUG NAME	Zavesca (miglustat)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 90 caps per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Zavesca (miglustat) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

GAUCHER DISEASE

For **initial** authorization:

1. Member is 18 years of age or older; AND
2. Member has mild or moderate type 1 Gaucher disease (Glucocerebrosidase deficiency confirmed in chart notes); AND
3. Member is unable to receive enzyme replacement therapy (chart notes confirming that enzyme replacement therapy is not a therapeutic option required) AND member did **not** take enzyme replacement therapy in the preceding 6 months; AND
4. Baseline of liver volume, spleen volume, hemoglobin concentration, and platelet count submitted with chart notes.
5. **Dosage allowed:** Recommended dosage is 100 mg administered orally three times a day at regular intervals.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease; AND
3. Reduction of liver volume and spleen volume is documented in chart notes.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource considers Zavesca (miglustat) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
06/29/2017	New policy for Zavesca created.

References:

1. Zavesca [package insert]. South San Francisco, CA; Actelion Pharmaceuticals US, Inc: February, 2016.

Effective date: 09/01/2017
Revised date: 06/29/2017