PHARMACY POLICY STATEMENT **Indiana 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 (Preferred Product) QUANTITY LIMIT— 90 caps per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Zavesca (miglustat) is a **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: 01/01/2018
Revised date: 06/29/2017