

## PRIOR AUTHORIZATION POLICY

**POLICY:** Fabry Disease – Galafold Prior Authorization Policy

- Galafold® (migalastat capsules – Amicus Therapeutics)

**REVIEW DATE:** 11/02/2022

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### OVERVIEW

Galafold, an oral alpha-galactosidase A ( $\alpha$ -Gal) pharmacological chaperone, is indicated for the treatment of adults with a confirmed diagnosis of **Fabry disease** and an amenable galactosidase alpha gene (*GLA*) variant based on in vitro assay data.<sup>1</sup>

### Disease Overview

Fabry disease is a rare inherited X-linked lysosomal storage disorder.<sup>2-4</sup> Absent or significantly reduced  $\alpha$ -Gal activity leads to the accumulation of globotriaosylceramide (GL-3) in a wide variety of cells throughout the body. The accumulation of GL-3 leads to progressive multisystem disease, primarily impacting the kidney, heart, and nervous system.<sup>3,4</sup> Life expectancy in patients with Fabry disease is reduced; median survival is typically 50 to 55 years in men and 70 years in women.<sup>2</sup>

Currently, there have been more than 800 mutations to the gene encoding  $\alpha$ -Gal identified.<sup>5</sup> About 60% are missense mutations resulting in single amino acid substitutions. Some of these mutated enzymes have activity levels similar to normal  $\alpha$ -Gal; however, they have been found to be unstable and are retained in the endoplasmic reticulum.

### POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Galafold. All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of patients treated with Galafold as well as the monitoring required for adverse events and long-term efficacy, approval requires Galafold to be prescribed by or in consultation with a physician who specializes in the condition being treated.

**Automation:** None.

### RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Galafold is recommended in those who meet the following criteria:

#### FDA-Approved Indication

1. **Fabry Disease.** Approve for 1 year if the patient meets the following criteria (A, B, and C):
  - A) Patient is  $\geq$  18 years of age; AND
  - B) Patient has an amenable galactosidase alpha gene (*GLA*) variant based on in vitro assay data; AND
  - C) The medication is prescribed by or in consultation with a geneticist, nephrologist, or a physician who specializes in the treatment of Fabry disease.

### CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Galafold is not recommended in the following situations:

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1. **Concurrent Use with Fabrazyme (agalsidase beta intravenous infusion).** One small study (n = 23) assessed a single dose of Galafold (150 mg or 450 mg) used concurrently with Fabrazyme or agalsidase alpha. While a single dose of Galafold significantly increased  $\alpha$ -Gal activity, the long-term safety and efficacy of concurrent use of Galafold and Fabrazyme has not been established.<sup>6</sup> Galafold is not FDA approved for concurrent use with Fabrazyme.
2. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

## REFERENCES

1. Galafold® capsules [prescribing information]. Cranbury, NJ: Amicus Therapeutics; December 2021.
2. Schiffmann R. Fabry Disease. *Handb Clin Neurol.* 2015;132:231-248.
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4. Laney DA, Bennett RL, Clarke V, et al. Fabry Disease Practice Guidelines: Recommendations of the National Society of Genetic Counselors. *J Genet Counsel.* 2013;22:555-564.
5. Benjamin ER, Della Valle MC, Wu X, et al. The Validation of Pharmacogenetics for the Identification of Fabry Patients to be Treated with Migalastat. *Genet Med.* 2017;19:430-438.
6. Warnock DG, Bichet DG, Holida M, et al. Oral Migalastat HCl Leads to Greater Systemic Exposure and Tissue Levels of Active  $\alpha$ -Galactosidase A in Fabry Patients when Co-Administered with Infused Agalsidase. *PLoS ONE.* 2015;10: e0134341.