# PREFERRED SPECIALTY MANAGEMENT POLICY

**POLICY:** Gaucher Disease – Enzyme Replacement Therapy Preferred Specialty Management Policy
- Cerezyme® (imiglucerase intravenous infusion – Genzyme)
- Elelyso™ (taliglucerase alfa intravenous infusion – Pfizer)
- Vpriv™ (velaglucerase alfa intravenous infusion – Shire)

**REVIEW DATE:** 08/31/2022

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## OVERVIEW

Cerezyme, Elelyso, and Vpriv are enzyme replacement therapy agents indicated for **long-term therapy in patients with a confirmed diagnosis of Type 1 Gaucher disease**.[1-3] The indication for Cerezyme specifies that it is used in Type 1 Gaucher disease that results in one or more of the following conditions: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly. All of these agents have efficacy data to support use in both adult and pediatric patients.

## POLICY STATEMENT

This Preferred Specialty Management program has been developed to encourage the use of the Preferred Product. For all medications (Preferred and Non-Preferred), the patient is required to meet the respective standard *Prior Authorization Policy* criteria. The program also directs the patient to try the Preferred Product prior to the approval of a Non-Preferred Product. Requests for Non-Preferred Products will also be reviewed using the exception criteria (below). Patients meeting the Prior Authorization criteria for a Non-Preferred Product who have not tried the Preferred Product will be offered a review for the Preferred Product. All approvals are provided for the duration noted below.

**Documentation:** Documentation is required for use of Cerezyme as noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to chart notes, prescription claims records, and prescription receipts.

**Automation:** None.

**Preferred Products:** Cerezyme
**Non-Preferred Products:** Elelyso, Vpriv

## RECOMMENDED EXCEPTION CRITERIA

| Non-Preferred Product | Exception Criteria |
|---|---|
| Elelyso | **1.** Approve for 1 year if the patient meets the following criteria (A and B):<br>**A)** Patient meets the standard *Gaucher Disease – Enzyme Replacement Therapy – Elelyso Prior Authorization* criteria; AND<br>**B)** Patient has tried Cerezyme **[documentation required]**.<br>**2.** For a patient who met criteria 1A but NOT 1B, offer to review for Cerezyme using the standard *Gaucher Disease – Enzyme Replacement Therapy – Cerezyme Prior Authorization* criteria.<br>**3.** If the patient is continuing therapy with Elelyso, approve for 1 year if the standard *Gaucher Disease – Enzyme Replacement Therapy – Elelyso Prior Authorization* criteria are met. |
| Vpriv | **1.** Approve for 1 year if the patient meets the following criteria (A and B):<br>**A)** Patient meets the standard *Gaucher Disease – Enzyme Replacement Therapy – Vpriv Prior Authorization* criteria; AND<br>**B)** Patient has tried Cerezyme **[documentation required]**.<br>**2.** For a patient who met criteria 1A but NOT 1B, offer to review for Cerezyme using the standard *Gaucher Disease – Enzyme Replacement Therapy – Cerezyme Prior Authorization* criteria.<br>**3.** If the patient is continuing therapy with Vpriv, approve for 1 year if the standard *Gaucher Disease – Enzyme Replacement Therapy – Vpriv Prior Authorization* criteria are met. |

## REFERENCES

1. Cerezyme® intravenous infusion [prescribing information]. Cambridge, MA: Genzyme; May 2022.
2. Vpriv™ intravenous infusion [prescribing information]. Cambridge, MA: Shire; October 2021.
3. Elelyso™ intravenous infusion [prescribing information]. New York, NY: Pfizer Labs; June 2022.