

## EXCEPTIONS CRITERIA GAUCHER DISEASE AGENTS

### PREFERRED PRODUCT: ELELYSO

#### POLICY

This policy informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

#### I. PLAN DESIGN SUMMARY

This program applies to the Gaucher disease products specified in this policy. Coverage for non-preferred products is provided based on clinical circumstances that would exclude the use of the preferred product and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to all members requesting treatment with a non-preferred product for an indication that is also FDA-approved for the preferred product.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

**Table. Gaucher Disease Agents**

	Product(s)
<b>Preferred</b>	<ul style="list-style-type: none"> <li>• <b>Elelyso</b> (taliglucerase alfa)</li> </ul>
<b>Non-preferred</b>	<ul style="list-style-type: none"> <li>• <b>Cerezyme</b> (imiglucerase)</li> <li>• <b>VPRIV</b> (velaglucerase alfa)</li> </ul>

#### II. EXCEPTION CRITERIA

Coverage for a non-preferred product is provided when the member has experienced a confirmed adverse event with the preferred product.

#### REFERENCES

1. Elelyso [package insert]. New York, NY: Pfizer, Inc; December 2016.
2. Cerezyme [package insert]. Cambridge, MA: Genzyme Corporation; May 2011.
3. VPRIV [package insert]. Lexington, MA: Shire Human Genetic Therapies, Inc.; April 2015.

Elelyso - Specialty Medical Benefit Gaucher's disease P2017

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