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)
Preferred	• **Elelyso** (taliglucerase alfa)
Non-preferred	• **Cerezyme** (imiglucerase) • **VPRIV** (velaglucerase alfa)

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.