 Draft Revised Policy: Do Not Implement

Avalglucosidase Alfa-ngpt (Nexviazyme™)

IMPORTANT REMINDER

We develop Medical Policies to provide guidance to Members and Providers. This Medical Policy relates only to the services or supplies described in it. The existence of a Medical Policy is not an authorization, certification, explanation of benefits or a contract for the service (or supply) that is referenced in the Medical Policy. For a determination of the benefits that a Member is entitled to receive under his or her health plan, the Member's health plan must be reviewed. If there is a conflict between the medical policy and a health plan or government program (e.g., TennCare), the express terms of the health plan or government program will govern.

The proposal is to add text/statements in red and to delete text/statements with strikethrough:

POLICY

INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication
Nexviazyme is indicated for the treatment of patients 1 year of age and older with late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency).

All other indications are considered experimental/investigational and not medically necessary.

DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review:
- Initial requests: acid alpha-glucosidase enzyme assay or genetic testing results supporting diagnosis.
- Continuation requests: chart notes documenting a positive response to therapy.

PRESCRIBER SPECIALTIES

This medication must be prescribed by or in consultation with a physician who specializes in the treatment of metabolic disease and/or lysosomal storage disorders.

COVERAGE CRITERIA ~~FOR INITIAL APPROVAL~~

Late-onset Pompe disease

Authorization of 12 months may be granted for treatment of late-onset Pompe disease when all of the following criteria are met:
- Member is 1 year of age or older.
- Diagnosis was confirmed by enzyme assay demonstrating a deficiency of acid alpha-glucosidase enzyme activity or by genetic testing.

CONTINUATION OF THERAPY

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in the coverage criteria ~~Section III~~ who are responding to therapy (e.g., improvement, stabilization, or slowing of disease progression for motor function, walking capacity, respiratory function, or muscle strength).

APPLICABLE TENNESSEE STATE MANDATE REQUIREMENTS

BlueCross BlueShield of Tennessee's Medical Policy complies with Tennessee Code Annotated Section 56-7-2352 regarding coverage of off-label indications of Food and Drug Administration (FDA) approved drugs when the off-label use is recognized in one of the statutorily recognized standard reference compendia or in the published peer-reviewed medical literature.

ADDITIONAL INFORMATION

For appropriate chemotherapy regimens, dosage information, contraindications, precautions, warnings, and monitoring information, please refer to one of the standard reference compendia (e.g., the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) published by the National Comprehensive Cancer Network®, Drugdex Evaluations of Micromedex Solutions at Truven Health, or The American Hospital Formulary Service Drug Information).

REFERENCES

1. Nexviazyme [package insert]. Cambridge, MA: Genzyme Corporation; September 2023.

EFFECTIVE DATE

ID_CHS