



## Medical Policy Manual **Draft Revised Policy: Do Not Implement**

### Imiglucerase (Cerezyme®)

Requires Step Therapy See “Step Therapy Requirements for Provider Administered Specialty Medications” Document at: [https://www.bcbst.com/docs/providers/Comm\\_BC\\_PAD\\_Step\\_Therapy\\_Guide.pdf](https://www.bcbst.com/docs/providers/Comm_BC_PAD_Step_Therapy_Guide.pdf)

#### 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 Indications

Cerezyme is indicated for treatment of adults and pediatric patients 2 years of age and older with Type 1 Gaucher disease that results in one or more of the following conditions: anemia, thrombocytopenia, bone disease, and/or hepatomegaly or splenomegaly.

##### Compendial Uses

- Gaucher disease type 2
- Gaucher disease type 3

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: beta-glucocerebrosidase (**glucosidase**) enzyme assay or genetic testing results supporting diagnosis.

#### **PRESCRIBER SPECIALTIES**

**This medication must be prescribed by or in consultation with physicians knowledgeable in the management of patients with Gaucher disease.**

#### **COERAGE CRITERIA FOR INITIAL APPROVAL**

##### **Gaucher disease type 1**

Authorization of 12 months may be granted for treatment of Gaucher disease type 1 when the diagnosis of Gaucher disease was confirmed by enzyme assay demonstrating a deficiency of beta-glucocerebrosidase (glucosidase) enzyme activity or by genetic testing.

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### Gaucher disease type 2

Authorization of 12 months may be granted for treatment of Gaucher disease type 2 when the diagnosis of Gaucher disease was confirmed by enzyme assay demonstrating a deficiency of beta-glucocerebrosidase (glucosidase) enzyme activity or by genetic testing.

### Gaucher disease type 3

Authorization of 12 months may be granted for treatment of Gaucher disease type 3 when the diagnosis of Gaucher disease was confirmed by enzyme assay demonstrating a deficiency of beta-glucocerebrosidase (glucosidase) enzyme activity or by genetic testing.

### CONTINUATION OF THERAPY

Authorization of 12 months may be granted for continued treatment of an indication listed in **the coverage criteria** section ††† when all of the following criteria are met:

- Member meets the criteria for initial approval.
- Member is not experiencing an inadequate response or any intolerable adverse events from therapy.

### 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. Cerezyme [package insert]. Cambridge, MA: Genzyme Corporation; **July 2024**.
2. Altarescu G, Hill S, Wiggs E, et al. The efficacy of enzyme replacement therapy in patients with chronic neuronopathic Gaucher's disease. *J Pediatr*. 2001;138:539-547.
3. Erikson A, Forsberg H, Nilsson M, Astrom M, Mansson JE. Ten years' experience of enzyme infusion therapy of Norrbottnian (type 3) Gaucher disease. *Acta Paediatr*. 2006;95:312-317.
4. Pastores GM, Hughes DA. Gaucher Disease. 2000 July 27 [Updated **December 7, 2023**]. In: Adam MP, Everman DB, Mirzaa GM, et al, editors. *GeneReviews*® [Internet]. Seattle, WA: University of Washington, Seattle; 1993-2023.
5. Kaplan P, Baris H, De Meirleir L, et al. Revised recommendations for the management of Gaucher disease in children. *Eur J Pediatr*. 2013;172:447-458.
6. **Gaucher Disease**. National Organization for Rare Disorders. (2024). *NORD guide to rare disorders*. Philadelphia: Lippincott Williams & Wilkins.



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of Tennessee

***Policy***

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**EFFECTIVE DATE**

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