Velmanase Alfa-tycv (Lamzede®)

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.

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

Lamzede is indicated for the treatment of non-central nervous system manifestations of alpha-mannosidosis in adult and pediatric patients.

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: alpha-mannosidase enzyme assay or genetic testing results supporting the diagnosis.
- Continuation of therapy requests: documentation (e.g., chart notes, lab results) of a response to therapy (e.g., improvement in 3-minute stair climbing test [3MSCT] from baseline, improvement in 6-minute walking test [6MWT] from baseline, improvement in forced vital capacity [FVC, % predicted] from baseline, reduction in serum or urine oligosaccharide concentration from baseline).

PRESCRIBER SPECIALTIES

This medication must be prescribed by or in consultation with a physician who specializes in the treatment of enzyme or metabolic disorders.

COVERAGE CRITERIA

Alpha-Mannosidosis

Authorization of 12 months may be granted for treatment of non-central nervous system manifestations of alpha-mannosidosis when the diagnosis is confirmed by either of the following:

- A documented deficiency of alpha-mannosidase activity as measured in blood leukocytes or fibroblasts, or
- Genetic testing results documenting pathogenic variant(s) in the MAN2B1 gene.

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 who are responding to therapy (e.g., improvement in 3-minute stair climbing test [3MSCT] from baseline, improvement in 6-minute walking test [6MWT] from baseline, improvement in forced vital capacity [FVC, % predicted] from baseline, reduction in serum or urine oligosaccharide concentration from baseline).

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. Lamzede [package insert]. Cary, NC: Chiesi USA Inc.; February 2023.
2. Malm D, Nilssen O. Alpha-Mannosidosis. In: GeneReviews. https://www.ncbi.nlm.nih.gov/books/NBK1396/ (Accessed on November 11, 2024).

EFFECTIVE DATE 7/31/2025

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