

Medical Policy Manual **Approved Rev: Do Not Implement until 12/2/25**

Sebelipase Alfa (Kanuma®)

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

Kanuma is indicated for the treatment of patients with a diagnosis of Lysosomal Acid Lipase (LAL) 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: lysosomal acid lipase enzyme assay or genetic testing results supporting diagnosis.
- Continuation requests: lab values or 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

Lysosomal Acid Lipase (LAL) Deficiency

Authorization of 12 months may be granted for treatment of LAL deficiency when both of the following criteria are met:

- Diagnosis of LAL deficiency was confirmed by enzyme assay demonstrating a deficiency of lysosomal acid lipase enzyme activity or by genetic testing; AND
- Member has alanine aminotransferase level (ALT) greater than or equal to 1.5 times the upper limit of normal (based on the age- and gender-specific normal ranges) on two consecutive ALT measurements obtained at least one week apart.

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** who are responding to therapy (e.g., improvement, stabilization, or slowing

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of disease progression for weight-for-age z-score if exhibiting growth failure, low-density lipoprotein [LDL], high-density lipoprotein [HDL], triglycerides, or alanine aminotransferase [ALT]).

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. Kanuma [package insert]. Boston, MA: Alexion Pharmaceuticals, Inc.; **July 2024**.
2. Burton BK, Balwani, M, Feillet F, et al. A Phase 3 Trial of Sebelipase Alfa in Lysosomal Acid Lipase Deficiency. N Engl J Med.2015;373:1010-20.

EFFECTIVE DATE 12/2/2025

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