Medical Policy:
Gaucher's Disease (Type 1)

Last review date: 6/13/2024

Applicable Products:
Cerezyme (imiglucerase)
Elelyso (taliglucerase alfa)
Vpriv (velaglucerase alfa)

Initial Approval Criteria:
Coverage may be approved if all of the following are met:

- Patient is at least 2 years old (Cerezyme only) or 4 years old (Elelyso and Vpriv); **AND**
- Patient has a documented diagnosis of Type 1 Gaucher Disease as confirmed by a betaglucosidase leukocyte (BGL) test with significantly reduced or absent glucocerebrosidase enzyme activity; **AND**
- If applicable: Trial and failure, intolerance, or a contraindication to the preferred products as listed in the medical drug list

Renewal Criteria:
Coverage may be renewed if all of the following are met:

- Patient continues to meet the Initial Approval Criteria; **AND**
- Absence of unacceptable toxicity; **AND**
- Disease response with treatment as defined by one or more of the following:
    - Improvement in symptoms (e.g., bone pain, fatigue, dyspnea, angina, abdominal distension, diminished quality of life, etc.)
    - Reduction in size of liver or spleen
    - Improvement in hemoglobin/anemia
    - Improvement in skeletal disease (e.g., increase in lumbar spine and/or femoral neck BMD, no bone crises or bone fractures, etc.)
    - Improvement in platelet counts

Length of Authorization:
1 year