

## Cerezyme® (imiglucerase) (Intravenous)

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### I. Length of Authorization

Coverage will be provided for 12 months and may be renewed.

### II. Dosing Limits

#### A. Quantity Limit (max daily dose) [NDC Unit]:

- Cerezyme 400 unit powder for injection: 18 vials per 14 days

#### B. Max Units (per dose and over time) [HCPCS Unit]:

- 720 billable units every 14 days

### III. Initial Approval Criteria <sup>1</sup>

Coverage is provided in the following conditions:

**Patient is required to meet Site of Service specialty infusion program requirements (refer to the [Dean Health Plan Site of Service Policy](#)).**

- Patient is at least 2 years of age; **AND**

#### Universal Criteria <sup>1</sup>

- Used as a single agent; **AND**

#### Type 1 Gaucher Disease † Φ <sup>1,6,9,12-15</sup>

- Patient has a documented diagnosis of Type 1 Gaucher Disease confirmed by one of the following:
  - Significantly reduced or absent glucocerebrosidase enzyme activity as measured by a beta-glucosidase leukocyte (BGL) test
  - Detection of mutations in the glucocerebrosidase (*GBA*) gene; **AND**
- Patient's disease results in one or more of the following:
  - Anemia-related symptoms [i.e., blood transfusion dependency and/or hemoglobin  $\leq$  11 g/dL (women and children) or  $\leq$  12 g/dL (men)]
  - Thrombocytopenia (platelet count  $\leq$  120,000/mm<sup>3</sup>)

- Hepatomegaly or splenomegaly
- Skeletal disease (e.g., lesions, remodeling defects and/or deformity of long bones, osteopenia/osteoporosis, etc.)
- Symptomatic disease (e.g., bone pain, fatigue, dyspnea, abdominal distension, diminished quality of life, etc.)

† FDA Approved Indication(s); ‡ Compendia Recommended Indication(s); Ⓢ Orphan Drug

#### IV. Renewal Criteria <sup>1,6,9,11,13-15</sup>

Coverage can be renewed based on the following criteria:

- Patient continues to meet the universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; **AND**
- Disease response with treatment as defined by one or more of the following (compared to pre-treatment baseline):
  - Improvement in anemia-related symptoms (i.e., improvement in hemoglobin and/or decrease in blood transfusion dependency)
  - Improvement in platelet counts
  - Reduction in size of liver or spleen
  - Improvement in skeletal disease (e.g., increase in lumbar spine and/or femoral neck BMD, no bone crises or bone fractures, etc.)
  - Improvement in symptoms (e.g., bone pain, fatigue, dyspnea, abdominal distension, quality of life, etc.); **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: hypersensitivity reactions, including anaphylaxis, etc.

#### V. Dosage/Administration <sup>1</sup>

Indication	Dose
Type 1 Gaucher Disease	<ul style="list-style-type: none"> <li>– Initial dosages range from 2.5 U/kg of body weight intravenously 3 times a week to 60 U/kg intravenously once every 2 weeks based on disease severity.</li> <li>– Titrate the dosage based on clinical manifestations of disease and therapeutic goals for the patient.</li> </ul>

#### VI. Billing Code/Availability Information

HCPCS Code:

- J1786 – Injection, imiglucerase, 10 units; 1 billable unit = 10 units

NDC:

- Cerezyme 400 unit powder for injection, single-dose vial: 58468-4663-xx

## VII. References

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5. Baldellou A, Andria G, Campbell PE, et al. Paediatric non-neuronopathic Gaucher disease: recommendations for treatment and monitoring. Eur J Pediatr 2004; 163:67.
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[diagnosis?search=gaucher%20disease%20type%201&source=search\\_result&selectedTitle=1~150&usage\\_type=default&display\\_rank=1#H11.](https://www.uptodate.com/contents/gaucher-disease-treatment?sectionName=ENZYMEREPLACEMENTTHERAPY&search=gaucher%20disease%20type%201&topicRef=2918&anchor=H4&source=see_link#H15131002)

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## Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
E75.22	Gaucher disease

## Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

The preceding information is intended for non-Medicare coverage determinations. Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determinations (NCDs) and/or Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. Local Coverage Articles (LCAs) may also exist for claims payment purposes or to clarify benefit eligibility under Part B for drugs which may be self-administered. The following link may be used to search for NCD, LCD, or LCA documents: <https://www.cms.gov/medicare-coverage-database/search.aspx>. Additional indications, including any preceding information, may be applied at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD/LCA): N/A

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	Applicable State/US Territory	Contractor
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC