Geisinger

POLICIES AND PROCEDURE MANUAL

Policy: MBP 18.0

Section: Medical Benefit Pharmaceutical Policy

Subject: Fabrazyme (agalsidase beta)

I. Policy:
Fabrazyme (agalsidase beta)

II. Purpose/Objective:
To provide a policy of coverage regarding Fabrazyme (agalsidase beta)

III. Responsibility:
A. Medical Directors
B. Medical Management
C. Pharmacy Department

IV. Required Definitions
1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than
3. the department requiring/authoring the policy.
4. Devised – the date the policy was implemented.
5. Revised – the date of every revision to the policy, including typographical and grammatical changes.
6. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards good medical treatment practiced by the general medical community;
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient

Medicaid Business Segment
Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

(i) the service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.

(ii) the service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.

(iii) the service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age

DESCRIPTION:
Fabrazyme (agalsidase beta) is approved by the FDA for use in members with Fabry disease. Fabry disease is a progressive X-linked genetic disorder which causes a deficiency in the enzyme alpha-galactosidase A. This deficiency allows glycosphingolipids to accumulate in the vascular endothelium and visceral tissues throughout the body.

CRITERIA FOR USE: Requires Prior Authorization by Medical Director or Designee

Fabrazyme is considered to be medically necessary when all of the following criteria are met:

- Physician provided documentation of a diagnosis of Fabry disease.
- The drug is recommended by a metabolic specialist with experience in treating Fabry disease.

AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

LIMITATIONS: Use in conditions other than Fabry disease is considered **investigational** and is **NOT COVERED.**

Note: For Medicaid (GHP Family), any requests for services that do not meet criteria set in the PARP will be evaluated on a case-by-case basis.

LINE OF BUSINESS:
Eligibility and contract specific benefit limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy.

This policy will be revised as necessary and reviewed no less than annually**.**

Devised: 7/25/05

Revised: 1/20/15 (formatting/add PA duration), 7/27/22 (Medicaid PARP statement)

Reviewed: 10/06, 11/07, 10/08, 2/10; 2/12, 2/14, 1/20/15, 3/31/16, 1/30/17, 10/31/17, 8/30/18, 8/29/19, 8/26/20, 8/3/21