

## 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 injection: 18 vials per 14 days

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

- 700 billable units every 14 days

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

Coverage is provided in the following conditions:

- 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>1,9-13</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**
- Adults only (i.e., patients at least 18 years or older): Patient's disease results in one or more of the following:
  - Anemia [i.e., hemoglobin less than or equal to 11 g/dL (women) or 12 g/dL (men)] not attributed to iron, folic acid, or vitamin B12 deficiency

- Moderate to severe hepatomegaly (liver size 1.25 or more times normal volume) or splenomegaly (spleen size 5 or more times normal volume)
- Skeletal disease (e.g., lesions, remodeling defects and/or deformity of long bones, osteopenia/osteoporosis, etc.)
- Symptomatic disease (e.g., bone pain, fatigue, dyspnea, angina, abdominal distension, diminished quality of life, etc.)
- Thrombocytopenia (platelet count less than or equal to 120,000/mm<sup>3</sup>)

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

#### IV. Renewal Criteria <sup>1,9-12</sup>

Coverage can be renewed based on the following criteria:

- Patient continues to meet 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 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; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: hypersensitivity reactions, 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>– Dosage adjustments should be made on an individual basis and may increase or decrease, based on achievement of therapeutic goals as assessed by routine comprehensive evaluations of the patient's clinical manifestations.</li> </ul>

#### VI. Billing Code/Availability Information

HCPCS Code:

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

## NDC:

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

## **VII. References**

1. Cerezyme [package insert]. Cambridge, MA; Genzyme Corporation.; December 2021. Accessed July 2022.
2. Anderson HC, et al. Consensus Statement by the International Collaborative Gaucher Group (ICGG) U.S. Coordinators on Individualization of ERT for Type-1 Gaucher Disease. September 2000.
3. Charrow, et al. Gaucher Disease: Recommendations on Diagnosis, Evaluation and Monitoring (Special Article). Archives of Internal Medicine 1998;158: 1754-1760.
4. Pastores GM, Weinreb NJ, Aerts H, et al. Therapeutic goals in the treatment of Gaucher disease. Semin Hematol 2004; 41:4.
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.
6. Charrow J, Andersson HC, Kaplan P, et al. The Gaucher Registry: Demographics and disease characteristics of 1698 patients with Gaucher disease. Arch Intern Med 2000; 160:2835.
7. Martins AM, Valadares ER, Porta G, et al. Recommendations on diagnosis, treatment, and monitoring for Gaucher disease. J Pediatr. 2009 Oct;155(4 Suppl):S10-8.
8. Kaplan P, Baris H, De Meirleir L, et al. Revised recommendations for the management of Gaucher disease in children. Eur J Pediatr. 2013 Apr;172(4):447-58. doi: 10.1007/s00431-012-1771-z. Epub 2012 Jul 8.
9. Pastores GM, Hughes DA. Gaucher Disease. GeneReviews. [www.ncbi.nlm.nih.gov/books/NBK1269/](http://www.ncbi.nlm.nih.gov/books/NBK1269/) (Accessed on July 28, 2022).
10. Grabowski GA, Barton NW, Pastores G, et al. Enzyme Therapy in Type 1 Gaucher Disease: Comparative Efficacy of Mannose-Terminated Glucocerebrosidase From Natural and Recombinant Sources. Ann Intern Med 1995 Jan 1;122(1):33-9. doi: 10.7326/0003-4819-122-1-199501010-00005.
11. Biegstraaten M, Cox TM, Belmatoug N, et al. Management goals for type 1 Gaucher disease: An expert consensus document from the European working group on Gaucher disease. Blood Cells, Molecules and Diseases 68 (2018) 203-208.
12. DuaPuri R, Kapoor S, Kishnani PS, et al. Diagnosis and Management of Gaucher Disease in India – Consensus Guidelines of the Gaucher Disease Task Force of the Society for Indian Academy of Medical Genetics and the Indian Academy of Pediatrics. Indian Pediatrics. 5:2018: 143-153.
13. Kaplan P, Andersson HC, Kacena KA, Yee JD. The clinical and demographic characteristics of nonneuronopathic Gaucher disease in 887 children at diagnosis. Arch Pediatr Adolesc Med. 2006 Jun;160(6):603-8.

## Appendix 1 – Covered Diagnosis Codes

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

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

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 Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Article may exist and compliance with these policies is required where applicable. They can be found at: <https://www.cms.gov/medicare-coverage-database/search.aspx>. Additional indications may be covered 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, LLC
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA, LLC
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

## Nondiscrimination & Language Access Policy

Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. We do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

We will:

Provide free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact us at the phone number shown on the inside cover of this contract, your id card, or aspirushealthplan.com.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with:

Nondiscrimination Grievance Coordinator  
Aspirus Health Plan, Inc.  
PO Box 1062  
Minneapolis, MN 55440  
Phone: 1.866.631.5404 (TTY: 711)  
Fax: 763.847.4010  
Email: customerservice@aspirushealthplan.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Nondiscrimination Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Language Assistance Services

**Albanian:** KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1.866.631.5404 (TTY: 711).

**Arabic:** تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بن اعلی رقم الهاتف 1.866.631.5404 (رقم هاتف الصم والبك : 711)

**French:** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelezle 1.866.631.5404 (ATS : 711).

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.866.631.5404 (TTY: 711).

**Hindi:** \_यान द\_ : य\_द आप िहंदी बोलते ह\_ तो आपके िलए मु\_त म\_ भाषा सहायता सेवाएं उपल\_ध ह\_। 1.866.631.5404 (TTY: 711) पर कॉल कर\_।

**Hmong:** LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.866.631.5404 (TTY: 711).

**Korean:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.866.631.5404 (TTY: 711)번으로 전화해 주십시오.

**Polish:** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.866.631.5404 (TTY: 711).

**Russian:** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.866.631.5404 (телетайп: 711).

**Spanish:** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.866.631.5404 (TTY: 711).

**Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1.866.631.5404 (TTY: 711)

**Traditional Chinese:** 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1.866.631.5404 (TTY: 711)。

**Vietnamese:** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.866.631.5404 (TTY: 711).

**Pennsylvania Dutch:** Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.866.631.5404 (TTY: 711).

**Lao:** ໄປດຊາຍ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1.866.631.5404 (TTY: 711).