Initial Approval: July 9, 2014
Revised Date: October 10, 2018; October 8, 2014

CRITERIA FOR PRIOR AUTHORIZATION

Enzyme Replacement Therapy

PROVIDER GROUP Pharmacy
Professional

MANUAL GUIDELINES The following drug requires prior authorization:
Agalsidase beta (Fabrazyme®)
Eliglustat (Cerdelga®)
Imiglucerase (Cerezyme®)
Migalastat (Galafold™)
Taliglucerase Alfa (Elelyso®)
Velaglucerase Alfa (VPRIV®)

CRITERIA FOR ENZYME REPLACEMENT THERAPY Must meet one of the following:

- For use of Cerdelga, Cerezyme, Elelyso, or VPRIV:
  - Patient must have a diagnosis of Type 1 Gaucher disease
- For use of Fabrazyme or Galafold:
  - Patient must have a diagnosis of Fabry disease

LENGTH OF APPROVAL 12 months

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DRUG UTILIZATION REVIEW COMMITTEE CHAIR

PHARMACY PROGRAM MANAGER
DIVISION OF HEALTH CARE FINANCE
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

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DATE DATE