Clinical Policy: Dornase Alfa (Pulmozyme)

Reference Number: LA.PHAR.212
Effective Date: 09.26.24
Last Review Date: 07.18.26
Line of Business: Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

****Please note: This policy is for medical benefit****

Description

Dornase alfa (Pulmozyme®) is a recombinant DNase enzyme.

FDA Approved Indication(s)

Pulmozyme is indicated in conjunction with standard therapies, for the management of pediatric and adult patients with cystic fibrosis (CF) to improve pulmonary function.

In CF patients with a forced vital capacity ≥ 40% of predicted, daily administration of Pulmozyme has also been shown to reduce the risk of respiratory tract infections requiring parenteral antibiotics.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of Louisiana Healthcare Connections® that Pulmozyme is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Cystic Fibrosis (must meet all)**:**

1. Diagnosis of CF;
2. Prescribed by or in consultation with a pulmonologist or an expert in treatment of cystic fibrosis;
3. Therapeutic plan includes concomitant use of standard CF therapies (e.g., antimicrobials, bronchodilators, mucolytics, chest physiotherapy);
4. Dose does not exceed both of the following (a and b):
   a. 5 mg per day;
   b. 2 ampules per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255.

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy LA.PMN.53.

II. Continued Therapy

A. Cystic Fibrosis (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Louisiana Healthcare Connections benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed both of the following (a and b):
   a. 5 mg per day;
   b. 2 ampules per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255.
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy LA.PMN.53.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – LA.PMN.53.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
CF: cystic fibrosis
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): known hypersensitivity to dornase alfa, Chinese Hamster Ovary cell products, or any component of the product
- Boxed warning(s): none reported

Appendix D: General Information

- Dornase alfa is recommended for chronic use in both mild and moderate-to-severe disease per the American Thoracic Society 2013 CF guidelines.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CF	One 2.5 mg ampule inhaled QD; some patients may benefit from BID administration	5 mg/day

VI. Product Availability

Inhalation solution in single-use ampules: 2.5 mg/2.5 mL

VII. References

1. Pulmozyme Prescribing Information. South San Francisco, CA: Genentech, Inc.; February 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/103532s5194lbl.pdf. Accessed April 9, 2026.
2. Mogayzel PJ, Naureckas ET, Robinson KA, et al. Cystic fibrosis pulmonary guidelines: Chronic medications for maintenance of lung health. Am J Respir Crit Care Med. April 1, 2013; 187(7): 680-689.
3. Kapnadak SG, Dimango E, Hadjiliadis D, et al. Cystic Fibrosis Foundation consensus guidelines for the care of individuals with advanced cystic fibrosis lung disease. *J Cyst Fibros* 2020 May;19(3):344-354. Doi: 10.1016/j.jcf.2020.02.015.
4. Cystic Fibrosis Foundation: Clinical Care Guidelines. Available at: https://www.cff.org/medical-professionals/clinical-care-guidelines. Accessed April 24, 2026.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J7639	Dornase alfa, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per mg

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Policy created.	05.09.23	08.28.23
Updated FDA approved indication section to align with language in prescriber information; references reviewed and updated.	02.21.24	09.26.24
No significant changes; references reviewed and updated.	11.13.24	01.27.25

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Annual review: no significant changes; for Appendix D, removed supplemental information on FEV_1 predicted; references reviewed and updated.	08.19.25	N/A, no material revisions
Annual review; for initial therapy, updated approval duration from 6 months to 12 months; references reviewed and updated.	07.18.26	10.07.26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

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This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

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