

## **Clinical Policy: Agalsidase Beta (Fabrazyme)**

Reference Number: CP.PHAR.158

Effective Date: 02.16

Last Review Date: 05.19

Line of Business: Commercial, HIM-Medical Benefit, Medicaid

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Agalsidase beta (Fabrazyme<sup>®</sup>) is a recombinant human alpha-galactosidase A enzyme.

### **FDA Approved Indication**

Fabrazyme is indicated for the treatment of Fabry disease.

### **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 health plans affiliated with Centene Corporation<sup>®</sup> that Fabrazyme is **medically necessary** when the following criteria are met:

## **I. Initial Approval Criteria**

### **A. Fabry Disease** (must meet all):

1. Diagnosis of Fabry disease confirmed by one of the following (a or b):
  - a. Enzyme assay demonstrating a deficiency of alpha-galactosidase activity;
  - b. DNA testing;
2. Age  $\geq$  8 years;
3. Dose does not exceed 1 mg per kg every 2 weeks.

### **Approval duration:**

**Medicaid/HIM** – 6 months

**Commercial** – 6 months or to the member's renewal date, whichever is longer

### **B. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid and HIM-Medical Benefit.

## **II. Continued Therapy**

### **A. Fabry Disease** (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;

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2. Member is responding positively to therapy as evidenced by improvement in the individual member's Fabry disease manifestation profile (*see Appendix D for examples*);
3. If request is for a dose increase, new dose does not exceed 1 mg per kg every 2 weeks.

**Approval duration:**

**Medicaid/HIM** – 12 months

**Commercial** – 6 months or to the member's renewal date, whichever is longer

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

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

**Approval duration: Duration of request or 6 months (whichever is less);** or

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid and HIM-Medical Benefit.

### 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 – CP.CPA.09 for commercial and CP.PMN.53 for Medicaid and HIM-Medical Benefit or evidence of coverage documents.

### IV. Appendices/General Information

*Appendix A: Abbreviation/Acronym Key*

FDA: Food and Drug Administration

*Appendix B: Therapeutic Alternatives*

Not applicable

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s): none reported.
- Boxed warning(s): none reported.

*Appendix D: General Information*

The presenting symptoms and clinical course of Fabry disease can vary from one individual to another. As such, there is not one generally applicable set of clinical criteria that can be used to determine appropriateness of continuation of therapy. Some examples, however, of improvement in Fabry disease as a result of Fabrazyme therapy may include improvement in:

- Fabry disease signs such as pain in the extremities, hypohidrosis or anhidrosis, or angiokeratomas
- Diarrhea, abdominal pain, nausea, vomiting, and flank pain
- Renal function
- Neuropathic pain, heat and cold intolerance, vertigo and diplopia
- Fatigue

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**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
Fabry disease	1 mg/kg IV every 2 weeks	1 mg/kg/2 weeks

**VI. Product Availability**

Single-use vial: 5 mg, 35 mg

**VII. References**

1. Fabrazyme Prescribing Information. Cambridge, MA: Genzyme Corporation; May 2010. Available at <http://www.fabrazyme.com>. Accessed February 27, 2019.
2. Desnick RJ, Brady R, Barranger J, et al. Fabry disease, an under-recognized multisystemic disorder: expert recommendations for diagnosis, management, and enzyme replacement therapy. *Ann Intern Med.* 2003; 138(4): 338-346.
3. Desnick RJ, Brady RO. Fabry disease in childhood. *J Pediatr.* 2004; 144(5 Suppl): S20-S26.

**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
J0180	Injection, agalsidase beta, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.48. Policy converted to new template.	01.16	02.16
Age restriction removed. Allergy history is removed as the drug can be continued in some cases. Initial approval extended to 6 months for consistency across similar policies. Positive response to therapy added. Background section converted to new template.	12.16	02.17
Policy converted to newer template. Age restriction added. Added general information appendix.	09.05.17	11.17
2Q 2018 annual review: no significant changes from previously approved corporate policy; policies combined for Commercial and Medicaid lines of business; HIM added; Commercial: added diagnosis confirmation testing requirement; added age limit; added requirement for documentation of positive response to therapy for reauthorization; changed approval durations from length of benefit to 6/12 months; references reviewed and updated.	02.26.18	05.18

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Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2019 annual review: no significant changes; references reviewed and updated.	02.27.19	05.19

**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. The Health Plan 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. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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 Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

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 the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

**Note: For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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