Elelyso® (taliglucerase alfa)
(Intravenous)

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I. Length of Authorization

Coverage will be provided for 12 months and may be renewed.

II. Dosing Limits

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

- 700 billable units every 14 days

III. Initial Approval Criteria [1]

Coverage is provided in the following conditions:

- Patient must have a contraindication, intolerance, or failure to **Cerezyme®** prior to consideration of Elelyso®; AND

- Patient is at least 4 years of age; **AND**

Universal Criteria [1]

- Used as a single agent; **AND**

Type 1 Gaucher Disease † Φ [1,6,13-17]

- 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**
- Patient's disease results in one or more of the following:
  - Anemia-related symptoms [i.e., blood transfusion dependency and/or hemoglobin ≤ 11 g/dL (women and children) or ≤ 12 g/dL (men)]
  - Thrombocytopenia (platelet count ≤ 120,000/mm^3)
  - Hepatomegaly or splenomegaly

- Skeletal disease (e.g., lesions, remodeling defects and/or deformity of long bones, osteopenia/osteoporosis, etc.)
- Symptomatic disease (e.g., bone pain, fatigue dyspnea, abdominal distension, diminished quality of life, etc.)

† FDA Approved Indication(s); ‡ Compendia Recommended Indication(s); Φ Orphan Drug

IV. Renewal Criteria [1,6,12,14-17]

Coverage can be renewed based on the following criteria:

- Patient continues to meet the universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: hypersensitivity reactions, including anaphylaxis, etc.; **AND**
- Disease response with treatment as defined by one or more of the following (compared to pre-treatment baseline):
  - Improvement in anemia-related symptoms (i.e., improvement in hemoglobin and/or decrease in blood transfusion dependency)
  - Improvement in platelet counts
  - Reduction in size of liver or spleen
  - Improvement in skeletal disease (e.g., increase in lumbar spine and/or femoral neck BMD, no bone crises or bone fractures, etc.)
  - Improvement in symptoms (e.g., bone pain, fatigue, dyspnea, abdominal distension, quality of life, etc.)

V. Dosage/Administration[1]

Indication	Dose
Type 1 Gaucher Disease	– Administer up to 60 units/kg every other week as an intravenous infusion. – In patients switching from a stable imiglucerase dosage to Elelyso, initiate Elelyso intravenous treatment with the same units/kg imiglucerase dosage and subsequently administer Elelyso every other week. – Dosage adjustments can be made based on achievement and maintenance of each patient's therapeutic goals.

VI. Billing Code/Availability Information

HCPCS Code:

- J3060 – Injection, taliglucerase alfa, 10 units; 1 billable unit = 10 units

NDC:

- Elelyso 200 unit powder for injection, single-dose vial: 00069-0106-xx

VII. References

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Appendix 1 – Covered Diagnosis Codes

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

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

The preceding information is intended for non-Medicare coverage determinations. 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 Determinations (NCDs) and/or Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. Local Coverage Articles (LCAs) may also exist for claims payment purposes or to clarify benefit eligibility under Part B for drugs which may be self-administered. The following link may be used to search for NCD, LCD, or LCA documents: https://www.cms.gov/medicare-coverage-database/search.aspx. Additional indications, including any preceding information, may be applied 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.

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
J (10)	TN, GA, AL	Palmetto GBA
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA
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)