Prior Authorization Review Panel

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CHC-MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
Policies submitted without this form will not be considered for review.

Plan: PA Health & Wellness	**Submission Date: 05/01/2020**
Policy Number: PA.CP.PHAR.161	**Effective Date: 01/2018** **Revision Date: 04/15/2020**
Policy Name: Galsulfase (Naglazyme)	

Type of Submission – Check all that apply:

- ☐ **New Policy**
- ✓ **Revised Policy***
- ☐ **Annual Review - No Revisions**
- ☐ **Statewide PDL** - *Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.*

***All revisions to the policy must be highlighted using track changes throughout the document.**

Please provide any changes or clarifying information for the policy below:

2Q 2020 annual review: references reviewed and updated.

Name of Authorized Individual (Please type or print): **Francis G. Grillo, MD**	**Signature of Authorized Individual:**

Clinical Policy: Galsulfase (Naglazyme)

Reference Number: PA.CP.PHAR.161
Effective Date: 01/18
Last Review Date: 04/2020

Coding Implications
Revision Log

Description
Galsulfase (Naglazyme®) is a hydrolytic lysosomal glycosaminoglycan-specific enzyme.

FDA approved indication
Naglazyme is indicated for the treatment of patients with mucopolysaccharidosis VI (MPS VI; Maroteaux-Lamy syndrome). Naglazyme has been shown to improve walking and stair-climbing capacity.

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 Pennsylvania Health and Wellness that Naglazyme is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Maroteaux-Lamy Syndrome (Mucopolysaccharidosis VI [MPS VI]): (must meet all):

1. Diagnosis of Maroteaux-Lamy syndrome (MPS VI) confirmed by one of the following:
   a. Enzyme assay demonstrating a deficiency in N-acetygalactosamine 4-sulfatase (arylsulfatase B) activity;
   b. DNA testing;
2. Dose does not exceed 1 mg/kg/week.

Approval duration: 6 months

B. Other diagnoses/indications: Refer to PA.CP.PMN.53

II. Continued Approval

A. Maroteaux-Lamy Syndrome (MPS VI): (must meet all)**:**

1. Currently receiving medication via Pennsylvania Health and Wellness benefit or member has previously met all initial approval criteria; or the Continuity of Care policy (PA.LTSS.PHAR.01) applies;
1. Member is responding positively to therapy as evidenced by improvement in the individual member's MPS VI (Maroteaux-Lamy syndrome) manifestation profile *(see Appendix D for examples)*;
2. If request is for a dose increase, new dose does not exceed 1 mg/kg/week.

Approval duration: 12 months

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

1. Currently receiving medication via Pennsylvania Health and Wellness benefit and documentation supports positive response to therapy; or the Continuity of Care policy (PA.LTSS.PHAR.01) applies; or
2. Refer to PA.CP.PMN.53

III. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
MPS VI: mucopolysaccharidosis VI

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 MPS VI can vary from one individual to another. Some examples, however, of improvement in MPS VI disease as a result of Naglazyme therapy may include improvement in:
- 12-minute walking test distance;
- 3-minute stair climb rate;
- Poor endurance;
- Vision problems;
- Respiratory infections;
- Breathing problems, sleep apnea;
- High blood pressure;
- Joint stiffness;
- Hepatomegaly, splenomegaly.

IV. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
MPS VI	1 mg/kg IV once weekly	1 mg/kg/week

V. Product Availability

Vial: 5 mg/5 mL

VI. References

1. Naglazyme Prescribing Information. Novato, CA: BioMarin Pharmaceutical, Inc.; December 2019. Available at http://www.naglazyme.com. Accessed February 20,2020.
2. Muenzer J. The mucopolysaccharidoses: a heterogeneous group of disorders with variable pediatric presentations. J Pediatr. 2004; 144(5 Suppl): S27-S34.

3. Akyol MU, Alden TD, Amartino H, et al. Recommendations for the management of MPS VI: systematic evidence- and consensus-based guidance. Orphanet J of Rare Dis, 2019;12(118)1-21.

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
J1458	Injection, galsulfase, 1 mg

Reviews, Revisions, and Approvals	Date	Approval Date
2Q 2018 annual review: Modified age restriction to 3 months per PI. Added prescriber requirement. Added max dose criteria. Added requirement for positive response to therapy. R eferences reviewed and updated.	02.13.18	04.18
2Q 2019 annual review: references reviewed and updated.	04/2019	
2Q 2020 annual review: references reviewed and updated.	04/2020	