Clinical Policy: Pegunigalsidase Alfa-iwxj (Elfabrio)

Reference Number: PA.CP.PHAR.512
Effective Date: 08/2023
Last Review Date: 04/2025

Description
Pegunigalsidase alfa-iwxj (Elfabrio®) is a hydrolytic lysosomal neutral glycosphingolipid-specific enzyme.

FDA Approved Indication(s)
Elfabrio is indicated for the treatment of adults with confirmed 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 PA Health & Wellness® that Elfabrio 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 A activity;
    b. DNA testing;
2. Prescribed by or in consultation with a clinical geneticist, cardiologist, nephrologist, neurologist, lysosomal disease specialist, or Fabry disease specialist;
3. Age ≥ 18 years;
4. Elfabrio is not prescribed concurrently with Fabrazyme® or Galafold®;
5. Documentation of member's current weight (in kg);
6. Dose does not exceed 1 mg/kg every 2 weeks.

Approval duration: 6 months

B. Other diagnoses/indications

1. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): PA.CP.PMN.53

II. Continued Therapy

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

1. Currently receiving medication via PA Health & Wellness benefit and documentation supports positive response to therapy or the Continuity of Care policy (PA.PHARM.01) applies;
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. Elfabrio is not prescribed concurrently with Fabrazyme® or Galafold®;
4. Documentation of member's current weight (in kg);

5. If request is for a dose increase, new dose does not exceed 1 mg/kg every 2 weeks.
   Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via PA Health & Wellness benefit and documentation supports positive response to therapy or the Continuity of Care policy (PA.PHARM.01) applies.
   Approval duration: Duration of request or 12 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): PA.CP.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 policies – PA.CP.PMN.53

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
- Boxed warning(s): hypersensitivity reactions including anaphylaxis

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
- Cornea verticillata

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

Injection solution in a single-dose vial: 20 mg/10 mL, 5 mg/2.5 mL

VII. References

1. Elfabrio Prescribing Information. Parma, Italy: Chiesi Farmaceutici; May 2024. Available at: https://resources.chiesiusa.com/Elfabrio/ELFABRIO_PI.pdf. Accessed March 10, 2025.
2. Ortiz, A., Germain DP, Desnick RJ, et al. Fabry disease revisited: management and treatment recommendations for adult patients. Molecular Genetics and Metabolism. 2018 Apr;123(4):416-27.
3. Linhart A, Nicholls K, West M, et al. Pegunigalsidase alfa for the treatment of Fabry disease – Phase III open label, switch-over study from agalsidase alfa – preliminary results. Poster abstract.
4. Schiffmann R, Goker-Alpan O, Holida M, et al. Pegunigalsidase alfa, a novel PEGylated enzyme replacement therapy for Fabry disease, provides sustained plasma concentrations and favorable pharmacodynamics: a 1-year Phase 1/2 clinical trial. J Inherit Metab Dis. 2019;42:534-44.
5. Hopkin RJ, Jeffries JL, Laney DA, et al. The management and treatment of children with Fabry disease: A United States-based perspective. Molecular Genetics and Metabolism 2016;117:104-13.
6. Germain DP, Fouilhoux A, Decramer S, et al. Consensus recommendations for diagnosis, management and treatment of Fabry disease in paediatric patients. Clinical Genetics. 2019;96:107-17.
7. Germain DP, Altarescu G, Barriales-Villa R, et al. An expert consensus on practical clinical recommendations and guidance for patients with classic Fabry disease. Molecular Genetics and Metabolism. July 2022;137:49-61.

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
J2508	Injection, pegunigalsidase alfa-iwxj, 1 mg

Reviews, Revisions, and Approvals	Date
Policy created	07/2023
3Q 2024 annual review: no significant changes; references reviewed and updated. Added HCPCS code [J2508].	07/2024
2Q 2025 annual review: no significant changes; added concomitant use exclusion to the Continued Therapy section to echo the exclusion which currently exists in the Initial Approval Criteria; added requirement for documentation of member's weight for dose calculation purposes; references reviewed and updated.	04/2025