

## ENZYME REPLACEMENT THERAPY

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Related Commercial Policy
<ul style="list-style-type: none"> <li>• <a href="#">Intravenous Enzyme Replacement Therapy (ERT) for Gaucher Disease</a></li> <li>• <a href="#">Specialty Medication Administration – Site of Care Review Guidelines</a></li> </ul>

### INSTRUCTIONS FOR USE

This Drug Policy provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Drug Policy is based. In the event of a conflict, the member specific benefit plan document supersedes this Drug Policy. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this Drug Policy. Other Policies and Coverage Determination Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary. This Drug Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

### BENEFIT CONSIDERATIONS

Before using this policy, please check the member specific benefit plan document and any federal or state mandates, if applicable.

Some Certificates of Coverage allow for coverage of experimental/investigational/unproven treatments for life-threatening illnesses when certain conditions are met. The member specific benefit plan document must be consulted to make coverage decisions for this service. Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances when certain conditions are met. Where such mandates apply, they supersede language in the benefit document or in the medical or drug policy. Benefit coverage for an otherwise unproven service for the treatment of serious rare diseases may occur when certain conditions are met. See the Policy and Procedure addressing the treatment of serious rare diseases.

#### **Essential Health Benefits for Individual and Small Group**

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits (“EHBs”). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this policy, it is important to refer to the member specific benefit plan document to determine benefit coverage.

This policy refers to the following enzyme replacement therapy products:

- [Adagen® \(pegademase bovine\)](#)
- [Aldurazyme® \(laronidase\)](#)
- [Elaprase® \(idursulfase\)](#)
- [Fabrazyme® \(agalsidase beta\)](#)
- [Kanuma™ \(sebelipase alfa\)](#)
- [Lumizyme® \(alglucosidase alfa\)](#)
- [Mepsevii™ \(vestronidase alfa-vjbk\)](#)
- [Naglazyme® \(galsulfase\)](#)
- [Revcovi™ \(elapegademase-lvlr\)](#)
- [Vimizim® \(elosulfase alfa\)](#)

**I. Adagen (pegademase bovine) and Revcovi (elapegademase-lvlr) are proven for the treatment of severe combined immunodeficiency disease (SCID) associated with a deficiency of adenosine deaminase (ADA).**

**Adagen and Revcovi are medically necessary when the following additional criteria are met:**

- A. For initial therapy, all of the following:
1. Diagnosis of SCID; **and**
  2. Deficiency of adenosine deaminase is confirmed by any of the following:
    - a. Deficiency or absence of ADA in plasma, lysed erythrocytes, fibroblasts (cultured from amniotic fluid), or chorionic villi
    - b. Increase in deoxyadenosine triphosphate (dATP) levels in erythrocyte lysates compared to laboratory standard
    - c. Decrease in ATP concentration in erythrocytes
    - d. Molecular genetic confirmation of mutations in both alleles of the *ADA1* gene
    - e. Positive screening by T cell receptor excision circles (TRECs);**and**
  3. One of the following:
    - a. Patient is not a suitable candidate for hematopoietic cell transplantation (HCT)
    - b. Patient has failed HCT;**and**
  4. Dosing is in accordance with the United States Food and Drug Administration approved labeling: dosing is started at 10 U/kg for the first dose, and titrated up to a maximum dose of 30 U/kg per week; **and**
  5. Initial authorization will be for no more than 12 months.
- B. For continuation therapy, all of the following:
1. Patient has previously received treatment with pegademase therapy; **and**
  2. Patient has experienced a positive clinical response to pegademase therapy (e.g., normalization of plasma ADA activity, erythrocyte dATP levels, improvement of disease symptoms, etc.); **and**
  3. Dosing is in accordance with the United States Food and Drug Administration approved labeling: appropriate maintenance dosing, up to a maximum dose of 30 U/kg per week; **and**
  4. Reauthorization will be for no more than 12 months.

**II. Aldurazyme (laronidase) is proven for the treatment of mucopolysaccharidosis I (MPS I).**

**Aldurazyme is medically necessary when the following additional criteria are met:**

- A. For initial therapy, all of the following:
1. Diagnosis of any of the MPS I syndromes confirmed by one the following:
    - a. Hurler variant (severe mucopolysaccharidosis I; also MPS IH)
    - b. Hurler-Scheie variant (attenuated mucopolysaccharidosis I; also MPS IHS)
    - c. Scheie variant (attenuated mucopolysaccharidosis I; also MPS IS);**and**
  2. Diagnosis of MPS I is confirmed by either of the following:
    - a. Deficiency or absence of fibroblast or leukocyte enzyme activity of alpha-L-iduronidase enzyme activity
    - b. Molecular genetic confirmation of mutations in the alpha-L-iduronidase gene;**and**
  3. Presence of clinical signs and symptoms of the disease (e.g., asymptomatic with affected older sibling, cardiac abnormalities, corneal clouding, dysostosis multiplex, hepatomegaly, restrictive lung disease, etc.); **and**
  4. Dosing is in accordance with the United States Food and Drug Administration approved labeling: Administered dose does not exceed 0.58 mg/kg intravenously once every week; **and**
  5. Initial authorization will be for no more than 12 months.

- B. For continuation therapy, all of the following:
  1. Patient has previously received treatment with laronidase therapy; **and**
  2. Patient has experienced a positive clinical response to laronidase therapy (e.g., improved endurance, improved functional capacity, reduced urine dermatan sulfate/heparan sulfate excretion, etc.); **and**
  3. Dosing is in accordance with the United States Food and Drug Administration approved labeling: administered dose does not exceed 0.58 mg/kg intravenously once every week; **and**
  4. Reauthorization will be for no more than 12 months.

**III. Elaprase (idursulfase) is proven for the treatment of mucopolysaccharidosis II (MPS II, Hunter Syndrome).**

**Elaprase is medically necessary when the following additional criteria are met:**

- A. For initial therapy, all of the following:
  1. Diagnosis of MPS II confirmed by one the following:
    - a. Deficiency in iduronate 2-sulfatase enzyme activity as measured in fibroblasts or leukocytes combined with normal enzyme activity level of another sulfatase
    - b. Molecular genetic testing for deletion or mutations in the iduronate 2-sulfatase gene; **and**
  2. Presence of clinical signs and symptoms of the disease (e.g., hepatosplenomegaly, skeletal deformities, dysostosis, neurocognitive decline, cardiovascular disorders, etc.); **and**
  3. Dosing is in accordance with the United States Food and Drug Administration approved labeling: administered dose does not exceed 0.5 mg/kg intravenously once every week; **and**
  4. Initial authorization will be for no more than 12 months.
- B. For continuation therapy, all of the following:
  1. Patient has previously received treatment with idursulfase therapy; **and**
  2. Patient has experienced a positive clinical response to idursulfase therapy (e.g., improved endurance, improved functional capacity, reduced spleen volume, reduced urine glycosaminoglycan excretion, etc.); **and**
  3. Dosing is in accordance with the United States Food and Drug Administration approved labeling: administered dose does not exceed 0.5 mg/kg intravenously once every week; **and**
  4. Reauthorization will be for no more than 12 months.

**IV. Fabrazyme (agalsidase beta) is proven for the treatment of Fabry disease.**

**Fabrazyme is medically necessary when the following additional criteria are met:**

- A. For initial therapy, all of the following:
  1. Diagnosis of Fabry disease as confirmed by one the following:
    - a. Absence or deficiency (< 5% of mean) of normal alpha-galactosidase A (α-Gal A) enzyme activity in leukocytes, dried blood spots, or serum analysis
    - b. Molecular genetic testing for deletion or mutations in the galactosidase alpha gene; **and**
  2. Presence of clinical signs and symptoms of the disease (e.g., Acroparesthesias, angiokeratomas, whorls, anhidrosis/hypohidrosis, renal disease, exercise/heat/cold intolerance, etc.); **and**
  3. Dosing is in accordance with the United States Food and Drug Administration approved labeling: administered dose does not exceed 1 mg/kg intravenously every two weeks; **and**
  4. Initial authorization will be for no more than 12 months.
- B. For continuation therapy, all of the following:
  1. Patient has previously received treatment with agalsidase therapy; **and**
  2. Patient has experienced a positive clinical response to agalsidase therapy (e.g., improved renal function, reduction in mean plasma GL-3 levels, decreased GL-3 inclusions, etc.); **and**
  3. Dosing is in accordance with the United States Food and Drug Administration approved labeling: administered dose does not exceed 1 mg/kg intravenously every two weeks; **and**
  4. Reauthorization will be for no more than 12 months.

**V. Kanuma (sebelipase alfa) is proven for the treatment of lysosomal acid lipase deficiency [LAL-D, Wolman disease (WD), cholesteryl ester disease (CESD)].**

**Kanuma is medically necessary when the following additional criteria are met:**

- A. For initial therapy, all of the following:
  1. Diagnosis of lysosomal acid lipase deficiency [LAL-D, Wolman disease (WD), cholesteryl ester disease (CESD)] as confirmed by one the following:
    - a. Absence or deficiency lysosomal acid lipase activity by dried blood spot test
    - b. Molecular genetic testing for deletion or mutations in the lipase A, lysosomal acid type (*LIPA*) gene; **and**
  2. Presence of clinical signs and symptoms of the disease (e.g., abdominal distention, hepatosplenomegaly, liver fibrosis, ascities, etc.); **and**

3. Dosing is in accordance with the United States Food and Drug Administration approved labeling by one of the following:
    - a. For rapidly progressive disease presenting within the first 6 months of life: administered initial starting dose is 1 mg/kg intravenously once weekly, up to a maximum of 3 mg/kg once weekly
    - b. Pediatric and adult patients with stabilized disease: administered dose does not exceed 1 mg/kg intravenously every other week;

**and**

  - 4. Initial authorization will be for no more than 12 months.
- B. For continuation therapy, all of the following:
1. Patient has previously received treatment with sebelipase therapy; **and**
  2. Patient has experienced a positive clinical response to sebelipase therapy [e.g., improved disease symptoms, improvement of laboratory values (LFTs, cholesterol, triglycerides), etc.]; **and**
  3. Dosing is in accordance with the United States Food and Drug Administration approved labeling by one of the following:
    - a. For rapidly progressive disease presenting within the first 6 months of life: administered dose is 1 mg/kg intravenously once weekly, up to a maximum of 3 mg/kg once weekly
    - b. Pediatric and adult patients with stabilized disease: administered dose does not exceed 1 mg/kg intravenously every other week;

**and**

  - 4. Reauthorization will be for no more than 12 months.

**VI. Lumizyme (alglucosidase alfa) is proven for the treatment of Pompe disease. Lumizyme is medically necessary when the following additional criteria are met:**

- A. For initial therapy, one (1. or 2.) of the following:
1. All of the following for infantile-onset Pompe disease:
    - a. Diagnosis of infantile-onset Pompe disease as confirmed by one the following:
      - i. Absence or deficiency (<1% of the lab specific normal mean) acid alpha-glucosidase deficiency (GAA) activity in skin fibroblasts
      - ii. Molecular genetic testing for deletion or mutations in the *GAA* gene;

**and**

    - b. Presence of clinical signs and symptoms of the disease (e.g., cardiac hypertrophy, respiratory distress, skeletal muscle weakness, etc.); **and**
    - c. Dosing is in accordance with the United States Food and Drug Administration approved labeling: administered dose does not exceed 20 mg/kg intravenously every two weeks; **and**
    - d. Initial authorization will be for no more than 12 months;

**or**

  - 2. All of the following for late-onset (non-infantile) Pompe disease:
    - a. Diagnosis of late-onset Pompe disease as confirmed by one the following:
      - i. Absence or deficiency (<40% of the lab specific normal mean) acid alpha-glucosidase deficiency (GAA) activity in lymphocytes, fibroblasts or muscle
      - ii. Molecular genetic testing for deletion or mutations in the *GAA* gene;

**and**

    - b. Presence of clinical signs and symptoms of the disease (e.g., cardiac hypertrophy, respiratory distress, skeletal muscle weakness, etc.); **and**
    - c. Dosing is in accordance with the United States Food and Drug Administration approved labeling: administered dose does not exceed 20 mg/kg intravenously every two weeks; **and**
    - d. Initial authorization will be for no more than 12 months.
- B. For continuation therapy, all of the following:
1. Patient has previously received treatment with alglucosidase therapy; **and**
  2. Patient has experienced a positive clinical response to alglucosidase therapy (e.g., improved respiratory/cardiac function, improved endurance, etc.); **and**
  3. Dosing is in accordance with the United States Food and Drug Administration approved labeling: administered dose does not exceed 20 mg/kg intravenously every two weeks; **and**
  4. Reauthorization will be for no more than 12 months.

**VII. Mepsevii (vestronidase alfa-vjkb) is proven for the treatment of mucopolysaccharidosis VII (Sly syndrome).**

**Mepsevii is medically necessary when the following additional criteria are met:**

- A. For initial therapy, all of the following:
1. Diagnosis of mucopolysaccharidosis VII confirmed by **either** of the following:
    - a. Absence or deficiency of fibroblast or leukocyte enzyme activity of beta glucuronidase
    - b. Molecular genetic confirmation of mutations in the *GUSB* gene.

**and**

2. Presence of clinical signs and symptoms of the disease (e.g., enlarged liver and spleen, joint limitations, airway obstruction or pulmonary problems, limitation of mobility while still ambulatory, etc.); **and**
  3. Dosing is in accordance with the United States Food and Drug Administration approved labeling: Administered dose does not exceed 4 mg/kg intravenously once every two weeks; **and**
  4. Initial authorization will be for no more than 12 months.
- B. For continuation therapy, all of the following:
1. Patient has previously received treatment with vestronidase therapy; **and**
  2. Patient has experienced a positive clinical response to vestronidase therapy (e.g., improved endurance, improved functional capacity, improved pulmonary function, etc.); **and**
  3. Dosing is in accordance with the United States Food and Drug Administration approved labeling: Administered dose does not exceed 4 mg/kg intravenously once every two weeks; **and**
  4. Reauthorization will be for no more than 12 months.

**VIII. Naglazyme (galsulfase) is proven for the treatment of mucopolysaccharidosis VI (Maroteaux-Lamy syndrome).**

**Naglazyme is medically necessary when all of the following additional criteria are met:**

- A. For initial therapy, all of the following:
1. Diagnosis of mucopolysaccharidosis VI confirmed by either of the following:
    - a. Absence or deficiency of fibroblast or leukocyte enzyme activity of N-acetylgalactosamine 4-sulfatase (arylsulfatase)
    - b. Molecular genetic confirmation of mutations in the ASB gene (5q13-q14);**and**
  2. Presence of clinical signs and symptoms of the disease (e.g., kyphoscoliosis, genu valgum, pectus carinatum, gait disturbance, growth deficiency, etc.); **and**
  3. Dosing is in accordance with the United States Food and Drug Administration approved labeling: administered dose does not exceed 1 mg/kg intravenously once every week; **and**
  4. Initial authorization will be for no more than 12 months.
- B. For continuation therapy, all of the following:
1. Patient has previously received treatment with galsulfase therapy; **and**
  2. Patient has experienced a positive clinical response to galsulfase therapy (e.g., improved endurance, improved functional capacity, reduced urine dermatan sulfate excretion, etc.); **and**
  3. Dosing is in accordance with the United States Food and Drug Administration approved labeling: administered dose does not exceed 1 mg/kg intravenously once every week; **and**
  4. Reauthorization will be for no more than 12 months.

**IX. Vimizim (elosulfase alfa) is proven for the treatment of mucopolysaccharidosis type IVA (MPS IVA; Morquio A syndrome).**

**Vimizim is medically necessary when all of the following additional criteria are met:**

- A. For initial therapy, all of the following:
1. Diagnosis of Morquio A syndrome confirmed by either of the following:
    - a. Absence or deficiency of fibroblast or leukocyte GALNS enzyme activity
    - b. Molecular genetic testing for mutations in the *GALNS* gene (16q24.3);**and**
  2. Presence of clinical signs and symptoms of the disease (e.g., kyphoscoliosis, genu valgum, pectus carinatum, gait disturbance, growth deficiency, etc.); **and**
  3. Dosing is in accordance with the United States Food and Drug Administration approved labeling: administered dose does not exceed 2 mg/kg IV once every week; **and**
  4. Initial authorization will be for no more than 12 months.
- B. For continuation therapy, all of the following:
1. Patient has previously received treatment with elosulfase alfa therapy; **and**
  2. Patient has experienced a positive clinical response to elosulfase alfa therapy (e.g., improved endurance, improved functional capacity, reduced urine keratan sulfate excretion); **and**
  3. Dosing is in accordance with the United States Food and Drug Administration approved labeling: administered dose does not exceed 2 mg/kg IV once every week; **and**
  4. Reauthorization will be for no more than 12 months.

**U.S. FOOD AND DRUG ADMINISTRATION (FDA)**

**Adagen** (pegademase bovine) is indicated for enzyme replacement therapy for adenosine deaminase (ADA) deficiency in patients with severe combined immunodeficiency disease (SCID) who are not suitable candidates for – or who have failed – bone marrow transplantation.<sup>9</sup>

**Aldurazyme** (laronidase) is indicated for patients with Hurler and Hurler-Scheie forms of mucopolysaccharidosis I (MPS I) and for patients with the Scheie form who have moderate to severe symptoms. The risks and benefits of treating mildly affected patients with the Scheie form have not been established. Aldurazyme has been shown to improve pulmonary function and walking capacity. Aldurazyme has not been evaluated for effects on the central nervous system manifestations of the disorder.<sup>10</sup>

**Elapraxe** (idursulfase) is indicated for patients with Hunter syndrome (mucopolysaccharidosis II, MPS II). Elapraxe has been shown to improve walking capacity in patients 5 years and older. In patients 16 months to 5 years of age, no data are available to demonstrate improvement in disease-related symptoms or long term clinical outcome; however, treatment with Elapraxe has reduced spleen volume similarly to that of adults and children 5 years of age and older. The safety and efficacy of Elapraxe have not been established in pediatric patients less than 16 months of age.<sup>11</sup>

**Fabrazyme** (agalsidase beta) is indicated for use in patients with Fabry disease. Fabrazyme reduces globotriaosylceramide (GL-3) deposition in capillary endothelium of the kidney and certain other cell types.<sup>12</sup>

**Kanuma** is indicated for the treatment of patients with a diagnosis of lysosomal Acid Lipase (LAL) deficiency.<sup>13</sup>

**Lumizyme** (alglucosidase alfa) is a hydrolytic lysosomal glycogen-specific enzyme indicated for patients with Pompe disease (acid  $\alpha$ -glucosidase (GAA) deficiency).<sup>14</sup>

**Mepsevii** (vestronidase alfa-vjvk) is indicated in pediatric and adult patients for the treatment of mucopolysaccharidosis type VII (MPS VII, Sly syndrome). The effect of Mepsevii on the central nervous system manifestations of MPS VII has not been determined.<sup>23</sup>

**Naglazyme** (galsulfase) is indicated for patients with mucopolysaccharidosis VI (MPS VI, Maroteaux-Lamy syndrome). Naglazyme has been shown to improve walking and stair-climbing capacity.<sup>15</sup>

**Revcovi** (elapegademase-lvlr) is indicated for the treatment of adenosine deaminase severe combined immune deficiency (ADA-SCID) in pediatric and adult patients.<sup>25</sup>

**Vimizim** (elosulfase alfa) is a hydrolytic lysosomal glycosaminoglycan (GAG)-specific enzyme FDA-labeled for patients with mucopolysaccharidosis type IVA (MPS IVA; Morquio A syndrome).<sup>1,5</sup>

## BACKGROUND

**Adagen** (pegademase bovine) provides specific replacement of the deficient enzyme adenosine deaminase (ADA). In the absence of the enzyme ADA, the purine substrates adenosine, 2'-deoxyadenosine and their metabolites are toxic to lymphocytes. The direct action of ADAGEN<sup>®</sup> (pegademase bovine) Injection is the correction of these metabolic abnormalities. Improvement in immune function and diminished frequency of opportunistic infections compared with the natural history of combined immunodeficiency due to ADA deficiency only occurs after metabolic abnormalities are corrected. There is a lag between the correction of the metabolic abnormalities and improved immune function. This period of time is variable, and has been reported to be from a few weeks to as long as 6 months. In contrast to the natural history of combined immunodeficiency disease due to ADA deficiency, a trend toward diminished frequency of opportunistic infections and fewer complications of infections has occurred in patients receiving Adagen (pegademase bovine).<sup>9</sup>

**Aldurazyme** (laronidase) is a polymorphic variant of the human enzyme  $\alpha$ -L-iduronidase that is produced by recombinant DNA technology in a Chinese hamster ovary cell line.  $\alpha$ -L-iduronidase (glycosaminoglycan  $\alpha$ -L-iduronohydrolase) is a lysosomal hydrolase that catalyzes the hydrolysis of terminal  $\alpha$ -L-iduronic acid residues of dermatan sulfate and heparan sulfate. Aldurazyme therapy is to provide exogenous enzyme for uptake into lysosomes and increase the catabolism of GAG.<sup>10</sup>

**Elapraxe** (idursulfase) is a formulation of idursulfase, a purified form of human iduronate-2-sulfatase, a lysosomal enzyme. Idursulfase is produced by recombinant DNA technology in a human cell line. Idursulfase is an enzyme that hydrolyzes the 2-sulfate esters of terminal iduronate sulfate residues from the glycosaminoglycans dermatan sulfate and heparan sulfate in the lysosomes of various cell types. Elapraxe is intended to provide exogenous enzyme for uptake into cellular lysosomes, leading to cellular internalization of the enzyme, targeting to intracellular lysosomes and subsequent catabolism of accumulated GAG.<sup>11</sup>

**Fabrazyme** (agalsidase beta) is a recombinant human  $\alpha$ -galactosidase A enzyme with the same amino acid sequence as the native enzyme.  $\alpha$ -galactosidase A catalyzes the hydrolysis of globotriaosylceramide (GL-3) and other  $\alpha$ -galactyl-terminated neutral glycosphingolipids, such as galabiosylceramide and blood group B substances to ceramide

dihexoside and galactose. Fabrazyme is intended to provide an exogenous source of  $\alpha$ -galactosidase A in Fabry disease patients. Nonclinical and clinical studies evaluating a limited number of cell types indicate that Fabrazyme will catalyze the hydrolysis of glycosphingolipids, including GL-3.<sup>12</sup>

**Kanuma** (sebelipase alfa) is a recombinant human lysosomal acid lipase (rhLAL). Lysosomal acid lipase is a lysosomal glycoprotein enzyme that catalyzes the hydrolysis of cholesteryl esters to free cholesterol and fatty acids and the hydrolysis of triglycerides to glycerol and free fatty acids. Sebelipase alfa binds to cell surface receptors via glycans expressed on the protein and is subsequently internalized into lysosomes. Sebelipase alfa catalyzes the lysosomal hydrolysis of cholesteryl esters and triglycerides to free cholesterol, glycerol and free fatty acids.<sup>13</sup>

**Lumizyme** (alglucosidase alfa) is a hydrolytic lysosomal glycogen-specific enzyme encoded by the predominant of nine observed haplotypes of the human acid  $\alpha$ -glucosidase (GAA) gene. Alglucosidase alfa is produced by recombinant DNA technology in a Chinese hamster ovary cell line. Alglucosidase alfa degrades glycogen by catalyzing the hydrolysis of  $\alpha$ -1,4- and  $\alpha$ -1,6- glycosidic linkages of lysosomal glycogen. Alglucosidase alfa provides an exogenous source of GAA. Binding to mannose-6-phosphate receptors on the cell surface has been shown to occur via carbohydrate groups on the GAA molecule, after which it is internalized and transported into lysosomes, where it undergoes proteolytic cleavage that results in increased enzymatic activity. It then exerts enzymatic activity in cleaving glycogen.<sup>14</sup>

**Mepsevii** (vestronidase alfa-vjvk) is a recombinant form of human beta-glucuronidase (GUS) and is intended to provide exogenous GUS enzyme for uptake into cellular lysosomes. Mannose-6-phosphate (M6P) residues on the oligosaccharide chains allow binding of the enzyme to cell surface receptors, leading to cellular uptake of the enzyme, targeting to lysosomes and subsequent catabolism of accumulated GAGs in affected tissues.<sup>23</sup>

**Naglazyme** (galsulfase) is a formulation of galsulfase, which is a purified human enzyme that is produced by recombinant DNA technology in a Chinese hamster ovary cell line. Galsulfase (glycosaminoglycan N-acetylgalactosamine 4-sulfatase) is a lysosomal enzyme that catalyzes the cleavage of the sulfate ester from terminal N-acetylgalactosamine 4-sulfate residues of glycosaminoglycans (GAG), chondroitin 4-sulfate and dermatan sulfate. Naglazyme is intended to provide an exogenous enzyme that will be taken up into lysosomes and increase the catabolism of GAG.<sup>15</sup>

**Revcovi** (elapegedemase-lvlr) Elapegedemase-lvlr is a recombinant adenosine deaminase (rADA) based on bovine amino acid sequence, conjugated to monomethoxypolyethylene glycol (mPEG). rADA is manufactured in E.coli and is covalently conjugated to mPEG with a succinimidyl carbamate linker to produce methoxypolyethylene glycol recombinant adenosine deaminase (SC-PEG rADA). The approximate molecular weight of elapegedemase-lvlr (SC-PEG rADA) is 113 KDa.<sup>25</sup>

**Vimizim** (elosulfase alfa) is a purified human enzyme produced by recombinant DNA technology which provides exogenous N-acetylgalactosamine-6-sulfatase. The mannose-6-phosphate-terminated oligosaccharide chains of elosulfase alfa bind to mannose-6-phosphate receptors of lysosomal cells resulting in cellular uptake of elosulfase alfa and increased catabolism of KS and C6S.<sup>5</sup>

## APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply.

### **Adagen**

HCPCS Code	Description
J2504	Injection, pegademase bovine, 25 IU
ICD-10 Diagnosis Code	Description
D81.3	Adenosine deaminase [ADA] deficiency

### **Aldurazyme**

HCPCS Code	Description
J1931	Injection, laronidase, 0.1 mg

ICD-10 Diagnosis Code	Description
E76.01	Hurler's syndrome
E76.02	Hurler-Scheie syndrome
E76.03	Scheie's syndrome

### **Elaprase**

HCPCS Code	Description
J1743	Injection, idursulfase, 1 mg

ICD-10 Diagnosis Code	Description
E76.1	Mucopolysaccharidosis, type II

### **Fabrazyme**

HCPCS Code	Description
J0180	Injection, agalsidase beta, 1 mg

ICD-10 Diagnosis Code	Description
E75.21	Fabry (-Anderson) disease

### **Kanuma**

HCPCS Code	Description
J2840	Injection, sebelipase alfa, 1 mg

ICD-10 Diagnosis Code	Description
E75.5	Other lipid storage disorders

### **Lumizyme**

HCPCS Code	Description
J0221	Injection, alglucosidase alfa, (Lumizyme), 10 mg

ICD-10 Diagnosis Code	Description
E74.02	Pompe disease

### **Mepsevii**

HCPCS Code	Description
J3397	Injection, vestronidase alfa-vjbk, 1 mg

ICD-10 Diagnosis Code	Description
E76.29	Other mucopolysaccharidoses (includes Sly syndrome)

### **Naglazyme**

HCPCS Code	Description
J1458	Injection, galsulfase, 1 mg

ICD-10 Diagnosis Code	Description
E76.29	Other mucopolysaccharidoses (includes Maroteaux-Lamy syndrome)

### **Revcovi**

HCPCS Code	Description
J3590	Unclassified biologic

ICD-10 Diagnosis Code	Description
D81.3	Adenosine deaminase [ADA] deficiency

### **Vimizim**

HCPCS Code	Description
J1322	Injection, elosulfase alfa, 1mg

ICD-10 Diagnosis Code	Description
E76.210	Morquio A mucopolysaccharidoses



**Proven****Adagen**

The efficacy of pegylated bovine adenosine deaminase was demonstrated by Hershfield et al., in a case study with two children with ADA deficiency and SCID. The medication was dosed weekly at approximately 15 U/kg given intramuscularly.<sup>16</sup> The dose maintained plasma ADA activity at two to three times the level of erythrocyte ADA activity in normal patients. After therapy was initiated, erythrocyte adenosine nucleotides increased and deoxyadenosine triphosphate (dATP) levels were reduced to less than 0.5 percent of total. The activity of S-adenosylhomocysteine hydrolase increased to normal in erythrocytes and nucleated marrow cells. The subjects also showed improvement in circulating T lymphocytes and an overall restoration of immune function, marked by an absence of infection and resumption of weight gain. Pegylated bovine adenosine deaminase demonstrated efficacy and shown to be preferable in safety and convenience to red blood cell transfusion.

**Aldurazyme**

To confirm the efficacy and safety of recombinant human  $\alpha$ -L-iduronidase (laronidase) in patients with mucopolysaccharidosis I (MPS I), Wraith et al., conducted a randomized, double-blinded, placebo-controlled, multicenter, multinational study of 45 patients with MPS I.<sup>17</sup> Patients were randomized to receive either laronidase (100 U/kg, n=22), or placebo (n=23), intravenously each week for 26 weeks. The primary endpoints assessed were the comparison of the median change from baseline to week 26 between the groups in percentage of predicted normal forced vital capacity (FVC) and in the 6-minute walk test (6MWT) distance, using the Wilcoxon rank sum test. After 26 weeks of treatment, patients in the laronidase group showed mean improvements in the percent of predicted normal FVC (5.6 percentage point reduction (median, 3.0; P= 0.009), and 38.1 meters in the 6MWT distance (median 38.5; P=0.066; P=0.039, analysis of covariance) compared to placebo. Patients who received laronidase also experienced reduced hepatomegaly (20% between-group difference, P=0.001), and urinary glycosaminoglycans (reduction of 54.1% compared to a 47.3% increase in the placebo group, p<0.001). More severely affected patients also had improved sleep apnea/hypopnea and shoulder flexion. The authors concluded that laronidase significantly improved respiratory function and physical capacity, reduced glycosaminoglycan storage, and had a favorable safety profile.

**Elaprase**

Muenzer et al, conducted a randomized, double-blind, placebo-controlled, multicenter, multinational clinical trial to evaluate the safety and efficacy of recombinant human iduronate-2-sulfatase (idursulfase) in the treatment of mucopolysaccharidosis II (MPS II).<sup>18</sup> Patients between the ages of 5 and 31 years old (n=96), were evenly randomized (n=32) to receive either weekly idursulfase (0.5 mg/kg) infusions, every other week (0.5mg/kg) infusions, or placebo. The primary efficacy assessment was the comparison between the placebo and weekly infusion group from the change in baseline to week 53 in a single, two-component composite variable combining %FVC as a measure of respiratory function and 6MWT as a measure of physical functional capacity using the O'Brien procedure for analysis. Secondary efficacy variables included changes in the individual components of the composite endpoint (6MWT distance and %FVC), absolute FVC, liver and spleen volumes measured by abdominal MRI, urine GAG excretion and passive joint range of motion. Patients in the weekly and every-other-week idursulfase groups exhibited significant improvement in the composite endpoint compared to placebo (P=0.0049 for weekly and P=0.0416 for every other week) after one year. The weekly dosing group experienced a 37-m increase in the 6-minute-walk distance (P=0.013), a 2.7% increase in percentage of predicted forced vital capacity (P=0.065), and a 160 mL increase in absolute forced vital capacity (P=0.001) compared to placebo group at 53 weeks. After 53 weeks in the intent to treat population, liver volume had decreased from baseline by  $25.3 \pm 1.6\%$  in the idursulfase weekly group and by  $24.0 \pm 1.7\%$  in the idursulfase every other week group. The change in both groups was statistically significantly greater than the change in the placebo group ( $-0.8 \pm 1.6\%$ , P < 0.0001 compared to either idursulfase group). At Week 53, the GAG levels in the idursulfase groups were significantly different than that of the placebo group (P < 0.0001 for either group compared to placebo). Idursulfase was generally well tolerated, but infusion reactions did occur. The authors concluded that weekly infusions of idursulfase produced a clinical benefit based on the significant improvements in the two-component composite endpoint, 6MWT distance and %FVC compared to placebo.

**Fabrazyme**

A multicenter, randomized, double-blind, placebo-controlled study was conducted to assess the efficacy of agalsidase beta to delay the onset of composite clinical outcome of renal, cardiovascular, and cerebrovascular events, and death in patients with advanced Fabry disease.<sup>19</sup> Patients (n=82), were randomized (2:1 treatment-to-placebo) to receive either an intravenous infusion of agalsidase beta (1mg/kg) or placebo every 2 weeks for up to 35 months. The primary endpoint was the time to first clinical event (renal, cardiac, or cerebrovascular event, or death). Thirteen (42%) of the 31 patients in the placebo group, and 14 (27%) of the 51 patients in the agalsidase-beta group experienced clinical events. Primary intention-to-treat analysis that adjusted for an imbalance in baseline proteinuria

showed that, compared with placebo, agalsidase beta delayed the time to first clinical event (hazard ratio, 0.47 [95% CI, 0.21 to 1.03]; P=0.06). Secondary analyses of protocol-adherent patients showed similar results (hazard ratio, 0.39 [CI, 0.16 to 0.93]; P=0.034). Ancillary subgroup analyses found larger treatment effects in patients with baseline estimated glomerular filtration rates greater than 55 mL/min per 1.73 m<sup>2</sup> (hazard ratio, 0.19 [CI, 0.05 to 0.82]; P=0.025) compared with 55 mL/min per 1.73 m<sup>2</sup> or less (hazard ratio, 0.85 [CI, 0.32 to 2.3]; P=0.75) (formal test for interaction, P=0.09). Most treatment-related adverse events were mild or moderate infusion-associated reactions, reported by 55% of patients in the agalsidase-beta group and 23% of patients in the placebo group. The authors concluded that therapy with agalsidase beta slowed the progression to the composite clinical outcome of renal, cardiac, and cerebrovascular complications and death compared with placebo in patients with advanced Fabry disease. The authors recommend therapeutic intervention before irreversible organ damage to provide greater clinical benefit.

### **Kanuma**

Burton et al conducted a phase 3 clinical trial to evaluate the safety and efficacy of enzyme-replacement therapy with sebelipase alfa.<sup>20</sup> This study was a multicenter, randomized, double-blind, placebo-controlled trial, enrolling 66 patients. Patients were randomized 1:1 to receive placebo (n=30) or sebelipase alfa (n=36) administered intravenously at 1mg/kg every other week. The placebo-controlled phase of the study was 20 weeks long, followed by an open-label treatment for all patients. The primary endpoint of the trial was the normalization of the alanine aminotransferase level. Secondary end points included additional disease-related assessments, safety, and side effects. Sebelipase alfa was associated with a significantly higher rate of normalization of the alanine aminotransferase level, (the primary end point) than was placebo (31% vs. 7%, P = 0.03). In addition, sebelipase alfa was associated with significant improvement in six consecutive secondary end points, as compared with placebo. The decrease from baseline in the mean alanine aminotransferase level was significantly greater in the sebelipase alfa group than in the placebo group (-58 U per liter vs. -7 U per liter, P<0.001). Similar results were seen with respect to normalization of the aspartate aminotransferase level (42% vs. 3%, P<0.001; mean reduction from baseline, -42 U per liter vs. -6 U per liter; P<0.001). An additional analysis of reduction in the alanine aminotransferase level with the use of recently applied criteria in studies of nonalcoholic fatty liver disease showed a response rate of 67% with sebelipase alfa versus 7% with placebo. The sebelipase alfa group had significantly greater mean percentage decreases from baseline in the LDL cholesterol level (difference from the change with placebo, -22.2 percentage points; P<0.001), the non-HDL cholesterol level (difference from placebo, -21.1 percentage points; P<0.001), and the triglyceride level (difference from placebo, -14.4 percentage points; P = 0.04) and a significantly greater mean percentage increase in the HDL cholesterol level (difference from placebo, 19.9 percentage points; P<0.001). The number of patients with adverse events was similar in the two groups; most events were mild and were considered by the investigator to be unrelated to treatment. Sebelipase alfa therapy resulted in a reduction in multiple disease-related hepatic and lipid abnormalities in children and adults with lysosomal acid lipase deficiency.

### **Lumizyme**

A randomized, double-blind, placebo-controlled, multicenter study was conducted to determine the safety and efficacy of alglucosidase alfa (GAA) for the treatment of late-onset Pompe's disease.<sup>21</sup> Ninety patients, 8 years of age or older, who were ambulatory, not dependent on invasive ventilation, were randomly assigned 2:1 to receive bi-weekly infusions of GAA (20mg/kg, n=60) or placebo (n=30). Co-primary efficacy end points were meters walked on the 6-minute walk test and percentage of the predicted FVC in the upright position. Secondary and tertiary efficacy end points included changes in the percentage of the predicted QMT leg score and QMT arm score, maximum inspiratory pressure, and maximum expiratory pressure. By 78 weeks, treatment with GAA had significantly increased both the distance walked on the 6-minute walk test and the percentage of the predicted FVC. The GAA group had a mean increase of 25.1 m on the 6-minute walk test (the average baseline was 332.2 m), whereas the placebo group had a decrease of 3.0 m (the average baseline was 317.9 m), for an estimated differential treatment effect of 28.1 m (P = 0.03). The estimated change in FVC, expressed as a percentage of each patient's predicted value, was an increase of 1.2 percentage points for the patients who received GAA and a decrease of 2.2 percentage points for the patients who received placebo, for an estimated treatment effect of 3.4 percentage points (P = 0.006). Patients in the two groups had similar frequencies of adverse events, serious adverse events, treatment-related adverse events, and infusion associated reactions. The authors concluded that, in this study population, treatment with alglucosidase alfa was associated with improved walking distance and stabilization of pulmonary function over an 18-month period.

### **Naglazyme**

The efficacy and safety of recombinant human arylsulfatase B (rhASB) for the treatment of mucopolysaccharidosis type VI (MPS VI), was confirmed in a Phase 3, randomized, double-blind, placebo-controlled, multicenter, multinational study.<sup>22</sup> Thirty-nine patients with MPS VI were randomized in a 1:1 ratio to receive weekly intravenous infusions of either rhASB 1mg/kg or placebo for 24 consecutive weeks. After 24 weeks, all patients completing treatment were enrolled in the open-label extension. The primary efficacy endpoint variable, the distance walked in a 12-minute walk test (12MWT), provided a measure of endurance. Secondary efficacy endpoints included the 3-minute stair climb (3MSC) and urine GAG levels. Tertiary end points included: (1) assessments of joint pain, joint stiffness, and physical energy level; (2) assessment of joint range of motion; and (3) assessment of hand dexterity as

evidenced by number of coins picked up in 1 minute. After 24 weeks, patients receiving rhASB walked on average 92 meters (m) more in the 12MWT ( $p=0.025$ ) and 5.7 stairs per minute more 3MSC ( $p=0.053$ ) than patients receiving placebo. Continued improvement was observed during the extension study. Urinary GAG declined by  $-227\pm 18$   $\mu\text{g}/\text{mg}$  more with rhASB than placebo ( $p<.001$ ). Infusions were generally safe and well tolerated. Patients exposed to drug experienced positive clinical benefit despite the presence of antibody to the protein. The authors concluded that rhASB significantly improved endurance, reduced urine GAG levels, and had an acceptable safety profile.

### **Revcovi**

The safety and efficacy of elapegedemase-lvlr was evaluated in a phase 3, open-label, multicenter, single-arm, one-way crossover study. The study consisted of three phases: Adagen Lead-in Phase (minimum of 3 weeks), the Revcovi Treatment Phase (weeks 1 through 21), and followed by the Revcovi Maintenance Phase. The efficacy endpoints evaluated included trough dAXP level, trough plasma ADA activity and immune status. Five of six patients reached the 21-week endpoint of the Treatment Phase. These patients (except for one value in a patient at Treatment Week 47) had erythrocyte dAXP concentration equal to or below 0.02 mmol/L. These patients had trough plasma ADA activity equal to or above 15 mmol/hr/L at 88/89 timepoints and maintained metabolic detoxification for at least 2 years under Revcovi treatment. Patients achieved trough plasma ADA activity above 30 mmol/hr/L by week 5, except for one patient who achieved this level at week 1. The mean trough plasma ADA activity for patients receiving Revcovi at a normalized dose of 0.2 mg/kg/week were  $34.3 \pm 6.6$  mmol/hr/L. The same patients had a mean trough plasma ADA activity of  $14.2 \pm 5.1$  mmol/hr/L when treated with Adagen at a normalized dose of 30 U/kg/week during the Lead-in Phase of the study. For these three patients who completed the primary endpoint or 21 weeks of treatment and received Revcovi for over 135 weeks, a positive trend between high trough plasma ADA activity and increased total lymphocyte counts was observed.<sup>25</sup>

Another study to evaluate the safety, efficacy and PK of Revcovi in patients with ADA-SCID included two phases, and evaluation and dose maintenance period. A total of four patients were enrolled in the study: two patients, who were on Adagen treatment within 4 weeks before entering the study, received a first dose of Revcovi that was calculated to be equivalent their prior Adagen dose. One patient, who did not receive Adagen within four weeks prior to entering the study. Over the dose adjustment phase of the study, the dose was titrated to meet criteria for dAXP level (equal to or below 0.02 mmol/L) and adequate trough ADA activity. The fourth patient was dosed with Revcovi at 0.4 mg/kg weekly for 16 weeks. All four of the patients in Study 2 achieved and maintained detoxification throughout their participation in the Treatment Phase of 21 weeks. Serum ADA activity increased after administering REVCovi for all four patients, with three patients achieving activity level over 15 mmol/hr/L during the Dose Maintenance Period. Total lymphocyte counts and B-/T-/NK-lymphocyte subset counts for three patients increased from screening to Day 15 during dose adjustment and were stable or increasing during the Maintenance Period.<sup>25</sup>

### **Vimizim**

In an ad hoc analysis of the primary phase 3 trial, Schweighardt et al examined the immunogenicity of elosulfase alfa and evaluated the effects of antibody formation on the overall efficacy and safety in patients with Morquio A syndrome.<sup>7</sup> During the trial, all patients treated with elosulfase alfa developed anti-elosulfase alfa antibodies (TAb). Those patients who received the once weekly therapy (QW) tested positive at a faster rate (all by week 4) versus the every other week (QOW) patients (all by week 16). The mean TAb titers by week 24 were similar in both dosing cohorts. About 20% of all study participants tested positive for TAb at baseline. Neutralizing antibodies (NAb) to elosulfase alfa, which inhibit its interaction to the mannose-6-phosphate receptor, and anti-elosulfase alfa IgE were also assayed throughout the trial. A majority (87%) of patients from the QW cohort and 80% from the QOW cohort tested positive for NAb by week 24 of the study. NAb is not of concern to efficacy, however, since elosulfase alfa is not active in the neutral pH of blood, but is active in the acidic pH of the lysosome, where NAb cannot penetrate, and thus is not a factor in hindering efficacy. Anti-elosulfase alfa IgE was detected in less than 10% of all patients receiving elosulfase alfa regimens: 8.6% of patients in the QW cohort and 6.8% in the QOW cohort. During the trial, however, most patients with serious adverse events (13 patients), including 3 patients with drug-related serious events of hypersensitivity, vomiting, and anaphylaxis, did not test positive for antidrug IgE. Regardless of TAb titers or NAb positivity, both dosing cohorts had a similar percentage of change in urinary keratan sulfate levels. There were no associations between TAb titers or NAb positivity and patient efficacy outcomes in either the QW or QOW groups, as measured by the 6-min walk test. The authors concluded that immunogenicity was not associated with reduced treatment effect of elosulfase alfa in patients with Morquio A syndrome.

To assess efficacy and safety of elosulfase alfa, researchers conducted a 24-week randomized, double-blind, placebo-controlled phase 3 trial [MOR-004] involving 176 patients (5 to 57 years of age) with mucopolysaccharidosis type IV A (Morquio A syndrome).<sup>1,2,6</sup> Patients were randomized (1:1:1) to receive elosulfase alfa 2.0 mg/kg/every other week (QOW), elosulfase alfa 2.0 mg/kg/week (weekly), or placebo for 24 weeks. The primary outcome measured was 6-min walk test (6MWT) distance. Secondary efficacy outcomes assessed were 3-min stair climb test (3MSCT) followed by change in urine keratan sulfate (KS). Patient safety was also evaluated. At baseline, patients could walk 30 to 325 m in 6 minutes; 82% had a history of musculoskeletal conditions including knee deformity (52%), kyphosis (31%), hip dysplasia (22%), prior spinal fusion surgery (22%), and arthralgia (20%). The estimated mean effect at week 24 on

6MWT (primary endpoint) versus placebo was 22.5 m (95 % CI 4.0, 40.9; p=0.017) for weekly and 0.5 m (95 % CI -17.8, 18.9; p=0.954) for QOW. The estimated mean effect on 3MSCT (secondary endpoint) was 1.1 stairs/min (95 % CI -2.1, 4.4; p=0.494) for weekly and -0.5 stairs/min (95 % CI -3.7, 2.8; p=0.778) for QOW. Normalized urine KS was reduced at 24 weeks in both regimens, however, the clinical significance of this finding has not been established. In the weekly dose group, 22.4 % of patients had adverse events leading to an infusion interruption/discontinuation requiring medical intervention (only 1.3 % of all infusions in this group), however, none of the adverse events led to permanent treatment discontinuation. No significant improvement in endurance in the 3MSCT rate was observed between these 2 groups. The performance (3MSCT rate or 6MWT) of patients receiving elosulfase alfa QOW did not differ significantly from placebo. Researchers concluded that these regimens were shown to provide generally safe enzyme replacement therapy (ERT) for patients with Morquio A syndrome. In MOR-005, patients who participated in the placebo-controlled trial were eligible to continue treatment in an open-label extension trial to evaluate the long-term safety and efficacy of elosulfase alfa.<sup>1, 6</sup> One hundred seventy-three of 176 patients enrolled in the extension trial in which patients received elosulfase alfa 2 mg/kg/wk (n=86) or Vimizim 2 mg/kg/QOW (n=87). In patients who continued to receive elosulfase alfa 2 mg/kg/wk for another 48 weeks (for a total of 72-week exposure), no further improvement in walking ability beyond the first 24 weeks was observed. Researchers concluded that elosulfase alfa may present as new treatment for Morquio A patients who have currently no medical care option other than symptomatic therapy of disease complications. Additionally, the study population of the trial can be considered representative of the general Morquio A population.

## CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Medicare does not have a National Coverage Determination (NCD) for the following Enzyme Replacement Therapies (ERT). Local Coverage Determinations (LCDs) for Adagen<sup>®</sup> (pegademase bovine), Elaprase<sup>®</sup> (idursulfase), Kanuma<sup>™</sup> (sebelipase alfa), Lumizyme<sup>®</sup> (alglucosidase alfa), Mepsevii<sup>™</sup> (vestronidase alfa-vjvk), Naglazyme<sup>®</sup> (galsulfase) and Vimizim<sup>®</sup> (elosulfase alfa) do not exist at this time.

LCDs do exist for Aldurazyme<sup>®</sup> (laronidase) and Fabrazyme<sup>®</sup> (agalsidase beta). See the LCDs for [Drugs and Biologics \(Non-chemotherapy\)](#).

In general, Medicare covers outpatient (Part B) drugs that are furnished "incident to" a physician's service provided that the drugs are not usually self-administered by the patients who take them. See the [Medicare Benefit Policy Manual, Chapter 15, §50 - Drugs and Biologicals](#). (Accessed August 25, 2018)

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#### POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
01/01/2019	Updated list of applicable Mepsevii HCPCS codes to reflect annual code edits; replaced J3590 with J3397. Policy 2018D0052I archived.
12/01/2018	Added Revcovi to coverage rationale, FDA, background, evidence and reference sections. Policy 2018D0052H archived.
11/01/2018	Annual review. Revised coverage rationale, updated CMS statement and references. Policy 2018D0052G archived.
08/01/2018	Off cycle review. Revised coverage rationale. Approved by the National Pharmacy and Therapeutics Committee on 07/18/2018. Policy 2018D0052F archived.
01/01/2018	Annual review. Added coverage rationale for Mepsevii. Updated US FDA, Background, Clinical Evidence, CMS Statement, and References. Approved by the National Pharmacy and Therapeutics Committee on 12/20/2017. Policy 2017D0052E archived.
12/01/2017	Off cycle review. Changed title to Enzyme Replacement Therapy. Added Adagen, Aldurazyme, Elaprase, Fabrazyme, Kanuma, Lumizyme, and Naglazyme to the coverage rationale. Updated US FDA, Background, Clinical Evidence, CMS Statement, and References. Approved by the National Pharmacy and Therapeutics Committee on 09/27/2017. Policy 2017D0052D archived.
10/01/2017	Annual review with no changes to the Coverage Rationale. Updated CMS statement. Approved by the National Pharmacy and Therapeutics Committee on 08/18/2017. Policy 2016D0052C archived.
09/01/2016	Annual review with no changes to the Coverage Rationale. Updated CMS statement and references. Approved by the National Pharmacy and Therapeutics Committee on 07/27/2016. Policy 2015D0052B archived.
10/01/2015	Policy revised per annual review with no changes to the Coverage Rationale. Added EHB language to Benefit Considerations. Updated CMS statement, Clinical Evidence

Date	Action/Description
	and references. Approved by the National Pharmacy and Therapeutics Committee on 08/19/2015. Policy 2015D0052A archived.
01/01/2015	New policy 2015D0052A. Approved by the National Pharmacy and Therapeutics Committee on 08/20/2014.