Clinical Policy: Agalsidase Beta (Fabrazyme)

Reference Number: CP.PHAR.158
Effective Date: 02.16
Last Review Date: 05.25
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

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

FDA Approved Indication(s)

Fabrazyme is indicated for the treatment of adult and pediatric patients 2 years of age and older 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 health plans affiliated with Centene Corporation® 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. Prescribed by or in consultation with a clinical geneticist, cardiologist, nephrologist, neurologist, lysosomal disease specialist, or Fabry disease specialist;
3. Age ≥ 2 years;
4. Fabrazyme is not prescribed concurrently with Galafold® or Elfabrio®;
5. Documentation of member's current weight (in kg);
6. Dose does not exceed 1 mg/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 (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or

b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

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

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
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. Fabrazyme is not prescribed concurrently with Galafold or Elfabrio;
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:
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. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

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, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

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
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
- 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

Single-use vials: 5 mg, 35 mg

VII. References

1. Fabrazyme Prescribing Information. Cambridge, MA: Genzyme Corporation; July 2024. Available at http://www.fabrazyme.com. Accessed January 8, 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;123:416-27.
3. 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.

4. 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.
5. 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
J0180	Injection, agalsidase beta, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2021 annual review: added a requirement for a clinical geneticist specialist and no concomitant use with Galafold, in line with the previously P&T-approved approach for Fabry disease for Galafold; RT4 policy update: updated age limit to ≥ 2 years of age per newly FDA-approved pediatric extension; references reviewed and updated.	03.15.21	05.21
Added other specialist types who might be involved in a Fabry patient's care, in line with the previously P&T-approved approach to specialists in Fabry disease.	08.18.21	11.21
2Q 2022 annual review: no significant changes; references reviewed and updated.	02.14.22	05.22
Template changes applied to other diagnoses/indications and continued therapy section.	09.30.22	
2Q 2023 annual review: no significant changes; references reviewed and updated.	02.08.23	05.23
2Q 2024 annual review: no significant changes; added exclusion for concomitant use with Elfabrio to align with the Elfabrio criteria; references reviewed and updated.	01.09.24	05.24
2Q 2025 annual review: no significant changes; added requirement for documentation of member's weight for dose calculation purposes; references reviewed and updated.	03.10.25	05.25

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.

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.