

**POLICY NAME**

Galafold (migalastat)

**POLICY #**

2665P

## Criteria

### Exclusion Criteria – Any of the following prevents coverage

- ☐ 2.1 Members with severe kidney impairment (eGFR < 30mL/minute/1.73m<sup>2</sup>)
- ☐ 2.2 Members with severe end-stage kidney disease requiring dialysis
- ☐ 2.3 Concomitant therapy with either Fabrazyme or Elfabrio

### Coverage Criteria

- ☐ 1.1 Diagnosis of Fabry disease with an amendable GLA variant (confirmed through genetic testing)
- ☐ 1.2 Age 18 years of age or older
- ☐ 1.3 Documentation of baseline number of GL-3 inclusions per kidney interstitial capillary
- ☐ 1.4 Prescribed by a geneticist (genetic disorder doctor) or specialist in the treatment of Fabry disease