Pharmacy Drug Policy Checklist

POLICY NAME	Cerezyme (imiglucerase)	POLICY #	1983P

Criteria

Coverage Criteria for the Treatment of Gaucher Disease

☐ **1.1** Diagnosis of type 1 Gaucher disease with one of the following
- Anemia (low level of red blood cells or hemoglobin)
- Bone disease
- Hepatomegaly (enlarged liver)
- Splenomegaly (enlarged spleen)
- Thrombocytopenia (low level of platelets in the blood)

☐ **1.2** Prescribed by a Geneticist (gene doctor)

☐ **1.3** Age 2 years or older

Exclusion Criteria – Any of the following prevents coverage

☐ **2.1** Not used in combination with Elelyso, Cerdelga, VPRIV, or Zavesca