

POLICY NAME	Elelyso (taliglucerase alfa)	POLICY #	2475P
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Criteria

Coverage Criteria for the Treatment of Gaucher disease

- ☐ Diagnosis of type 1 Gaucher disease confirmed by genetic testing or enzyme assay
- ☐ Age 4 years or older
- ☐ Prescribed by a Geneticist (gene specialist)

Exclusion Criteria – Any of the following prevents coverage

- ☐ Not used in combination with Zavesca, Cerdelga, Cerezyme or VPRIV