Pharmacy Drug Policy Checklist

POLICY NAME	Zavesca (miglustat)	POLICY #	1065P

Criteria

Exclusion Criteria – Any of the following prevents coverage

- ☐ **2.1** Zavesca will not be approved if used in combination with Cerezyme, Elelyso, or VPRIV or Cerdelga

Coverage Criteria for Treatment of Gaucher Disease

- ☐ **1.1** Diagnosis of mild-to-moderate type I Gaucher Disease confirmed by gene testing or enzyme assay
- ☐ **1.2** Documented clinically significant manifestations of Gaucher disease such as enlarged spleen, enlarged livery, avascular necrosis (bone blood loss), Erlenmeyer flask deformity (bone enlargement), decrease in bone mineral density, or pathological fracture
- ☐ **1.3** Prescribed by a Geneticist (gene doctor), Hematologist (blood doctor), Oncologist (cancer doctor), or physician specializing in the treatment of Gaucher Disease
- ☐ **1.4** Age 18 years or older
- ☐ **1.5** If a biological female, documented negative pregnancy test

Approval Time

- ☐ **3.1** Initial: 12 months
- ☐ **3.2** Reauthorization: 12 months with documented clinical benefit from therapy CPT Codes HCPCS Codes References