

<b>POLICY NAME</b>	VPRIV (velaglucerase alfa)	<b>POLICY #</b>	2483P
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## Criteria

### Coverage Criteria for the Treatment of Gaucher disease

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

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

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