Pharmacy Drug Policy Checklist

POLICY NAME	Xenpozyme (olipudase alfa)	POLICY #	

Criteria

Exclusion Criteria – Any of the following prevents coverage

- ☐ **2.1** Patient has evidence of progressing nerve or brain abnormalities
- ☐ **2.2** Patient requires ventilator support

Coverage Criteria

- ☐ **1.1** Diagnosis of acid sphingomyelinase deficiency (ASMD) type B or A/B confirmed by enzyme assay and supported by the following:
  - Diffusion capacity of the lungs for carbon monoxide (DLco) ≤70% of predicted normal value
  - Spleen volume ≥6 multiples of normal for adults or ≥5 multiples of normal for pediatric patients
- ☐ **1.2** Prescribed by or in consultation with a specialist familiar with the treatment of this disease
- ☐ **1.3** Documentation of baseline liver function tests
- ☐ **1.4** Clinical review for coverage is completed by both a pharmacist and medical director