

<b>POLICY NAME</b>	Xenpozyme (olipudase alfa)	<b>POLICY #</b>	3188P
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## Criteria

### Coverage Criteria

- ☐ 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)  $\leq 70\%$  of predicted normal value
  - Spleen volume  $\geq 6$  multiples of normal for adults or  $\geq 5$  multiples of normal for pediatric patients
- ☐ Prescribed by or in consultation with a specialist familiar with the treatment of this disease
- ☐ Documentation of baseline liver function tests
- ☐ Clinical review for coverage is completed by both a pharmacist and medical director

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

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