Pharmacy Drug Policy Checklist

POLICY NAME	Galafold (migalastat)	POLICY #	2665P

Criteria

Coverage Criteria

- ☐ **1.1** Diagnosis of Fabry disease with an amendable GLA variant (confirmed through genetic testing)
- ☐ **1.2** Age 18 years of age or older
- ☐ **1.3** Documentation of baseline number of GL-3 inclusions per kidney interstitial capillary
- ☐ **1.4** Prescribed by a geneticist (genetic disorder doctor) or specialist in the treatment of Fabry disease

Exclusion Criteria – Any of the following prevents coverage

- ☐ **2.1** Members with severe kidney impairment (eGFR < 30mL/minute/1.73m2)
- ☐ **2.2** Members with severe end-stage kidney disease requiring dialysis
- ☐ **2.3** Concomitant therapy with either Fabrazyme or Elfabrio