Pharmacy Drug Policy Checklist

POLICY NAME	Elelyso (taliglucerase alfa)	POLICY #	2475P

Criteria

Coverage Criteria for the Treatment of Gaucher disease

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

Exclusion Criteria – Any of the following prevents coverage

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