Health Alliance™

Pharmacy Drug Policy Checklist

POLICY NAME	Cerezyme (imiglucerase)	POLICY #	1983P

Criteria

Coverage Criteria for the Treatment of Gaucher Disease

- ☐ Diagnosis of type 1 Gaucher disease with one of the following
  - Anemia (low level of red blood cells or hemoglobin)
  - Bone disease
  - Hepatomegaly (enlarged liver)
  - Splenomegaly (enlarged spleen)
  - Thrombocytopenia (low level of platelets in the blood)
- ☐ Prescribed by a Geneticist (gene doctor)
- ☐ Age 2 years or older

Exclusion Criteria – Any of the following prevents coverage

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