Pharmacy Drug Policy Checklist

POLICY NAME	Lumizyme (alglucosidase)	POLICY #	2477P

Criteria

Exclusion Criteria – Any of the following prevents coverage

☐ **2.1** Use along with Nexviazyme is considered a duplication and is excluded from coverage.

Coverage Criteria for the Treatment of Pompe disease

☐ **1.1** Diagnosis of Pompe disease, supported by the following:

- i Enzyme assay showing a deficiency of acid alpha-glucosidase (GAA) activity in the blood, skin, or muscle ii Genetic testing showing a mutation in the GAA gene

☐ **1.2** Age 1 year or older

☐ **1.3** Prescribed by a geneticist (gene specialist) or specialist in Pompe disease

☐ **1.4** Documentation and imaging to rule out presence of an enlarged heart (cardiomyopathy)

☐ **1.5** Documentation showing baseline percent-predicted forced vital capacity (FVC) and 6-minute walk test (6MWT)

☐ **1.6** Review of chart notes documenting diagnosis and confirming that patient has met all above requirements for treatment with Nexviazyme by both a pharmacist and medical director