

**POLICY NAME**

Cerezyme (imiglucerase)

**POLICY #**

1983P

## Criteria

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

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

### Coverage Criteria for the Treatment of Gaucher Disease

- ☐ 1.1 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)
- ☐ 1.2 Prescribed by a Geneticist (gene doctor)
- ☐ 1.3 Age 2 years or older