

Medical Policy

Gaucher's Disease (Type 1)

Last review date: **1/1/2026**

Prior review date: **7/1/2025**

Applicable Products

Cerezyme (imiglucerase)

Elelyso (taliglucerase alfa)

Vpriv (velaglucerase alfa)

Initial Approval Criteria

Coverage may be approved if all of the following are met:

- Patient is at least 2 years old (Cerezyme only) or 4 years old (Elelyso and Vpriv); **AND**
- Patient has a documented diagnosis of Type 1 Gaucher Disease as confirmed by a betaglucosidase leukocyte (BGL) test with significantly reduced or absent glucocerebrosidase enzyme activity; **AND**
- If applicable: Trial and failure, intolerance, or a contraindication to the preferred products as listed in the medical drug list

Renewal Criteria

Coverage may be renewed if all of the following are met:

- Patient continues to meet the Initial Approval Criteria; **AND**
- Absence of unacceptable toxicity; **AND**
- Disease response with treatment as defined by one or more of the following:
 - Improvement in symptoms (e.g., bone pain, fatigue, dyspnea, angina, abdominal distension, diminished quality of life, etc.)
 - Reduction in size of liver or spleen
 - Improvement in hemoglobin/anemia
 - Improvement in skeletal disease (e.g., increase in lumbar spine and/or femoral neck BMD, no bone crises or bone fractures, etc.)
 - Improvement in platelet counts

Length of Authorization

1 Year

This policy is designed to address medical guidelines that are appropriate for the majority of individuals with a particular disease, illness, or condition. Each person's unique clinical or other circumstances may warrant individual consideration, based on review of applicable medical records, as well as other regulatory, contractual and/or legal requirements.

Medical policies do not constitute medical advice, nor are they intended to govern the practice of medicine. They are intended to reflect reimbursement and coverage guidelines. Coverage for services may vary for individual members, based on the terms of the benefit contract.