

Prior Authorization Criteria
Fabry Disease Medications

All requests for Fabry Disease Medications require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Fabry disease medications include Galafold (migalastat) or Fabrazyme (agalsidase beta). New products with this classification will require the same documentation.

For all requests for Fabry disease medications all of the following criteria must be met:

Coverage may be provided with a diagnosis of Fabry Disease and the following criteria is met:

- Diagnosis has been confirmed by biochemical/genetic confirmation by ONE of the following:
 - α -galactosidase A (α -Gal A) activity in plasma, isolated leukocytes, and/or cultured cells.
 - Plasma or urinary globotriaosylceramide (Gb3/GL-3) or globotriaosylsphingosine (lyso-Gb3).
 - Detection of pathogenic mutations in the alpha-galactosidase A (alpha-Gal A; galactosidase alpha [GLA]) gene by molecular genetic testing.
- Documentation the member is ONE of the following:
 - Symptomatic (i.e. intermittent episodes of burning pain in the extremities (acroparesthesias); cutaneous vascular lesions (angiokeratomas); diminished perspiration (hypo- or anhidrosis); characteristic corneal and lenticular opacities; abdominal pain, nausea, and/or diarrhea of unknown etiology in young adulthood; left ventricular hypertrophy (LVH) or hypertrophic cardiomyopathy of unknown etiology, particularly in young adults; arrhythmias of unknown etiology, particularly in young adults; stroke of unknown etiology at any age; chronic kidney disease (CKD) and/or proteinuria of unknown etiology; multiple renal sinus cysts discovered incidentally)
 - Asymptomatic with ALL of the following:
 - Assigned male at birth
 - Have classic Fabry mutations
 - Documentation of biopsy evidence indicating initiation of therapy is medically necessary.
- Medication must be prescribed by or in association with a metabolic specialist, geneticist, dermatologist, neurologist, nephrologist, rheumatologist, or cardiologist.
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

For all requests for Fabrazyme (agalsidase beta)

- **Initial Duration of Approval:** 12 months
- **Reauthorization Criteria**



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Updated: 06/2021
PARP Approved: 06/2021

○ Chart documentation demonstrating clinical benefit and tolerance to Fabrazyme

- **Reauthorization Duration of approval:** 12 months

For all requests for Galafold (migalastat) all of the following criteria must be met:

- Member must have amenable GLA variant that is interpreted by a clinical genetics professional as causing Fabry disease (pathogenic, likely pathogenic) in the clinical context of the patient.
- Exclusion criteria
 - Member must not have severe renal impairment (eGFR <30 mL/minute/1.73 m²)
 - Member must not have end-stage renal disease requiring dialysis
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
 - Chart documentation demonstrating clinical benefit and tolerance to Galafold.
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

**FABRY DISEASE MEDICATIONS
PRIOR AUTHORIZATION FORM**

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway HealthSM Pharmacy Services. **FAX:** (888) 245-2049
 If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Medication Initiated:

Billing Information

This medication will be billed: at a pharmacy **OR** medically,
 JCODE: _____

Place of Service: Hospital Provider's office Member's home Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:
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1. Has member's diagnosis been confirmed by biochemical/genetic confirmation by ONE of the following:

- α -galactosidase A (α -Gal A) activity in plasma, isolated leukocytes, and/or cultured cells.
 Yes No
- Plasma or urinary globotriaosylceramide (Gb3/GL-3) or globotriaosylsphingosine (lyso-Gb3).
 Yes No
- Detection of pathogenic mutations in the GALA/GLA gene by molecular genetic testing.
 Yes No

2. Please select all of the following that apply:

- The member is symptomatic (please provide documentation of symptoms)
- The member is asymptomatic with the following:
- Assigned male at birth
 - Has classic Fabry mutations
- The member had a biopsy indicating initiation of enzyme replacement therapy is medically necessary (Please provide documentation).

For Galafold (Migalastat) only:

- 1) Does the member have amenable GLA variant that has been interpreted by a clinical genetics professional as causing Fabry disease (pathogenic, likely pathogenic) in the clinical context of the patient?
 Yes No
 Please provide variant: _____
- 2) Does the member have severe renal impairment (eGFR <30 mL/minute/1.73 m²)?
 Yes No
- 3) Does the member have end-stage renal disease requiring dialysis?
 Yes No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

For Fabrazyme:

Has the member demonstrated clinical benefit and tolerance with treatment? Yes No

Please describe:

For Galafold:

Has the member experienced clinical benefit and tolerance with treatment? Yes No

Please describe:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature

Date

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