

## Clinical Policy: Galsulfase (Naglazyme)

Reference Number: CP.PHAR.161

Effective Date: 02.16

Last Review Date: 05.22

Line of Business: Commercial, HIM, Medicaid

[Coding Implications](#)  
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

Galsulfase (Naglazyme<sup>®</sup>) is a hydrolytic lysosomal glycosaminoglycan-specific enzyme.

### FDA approved indication

Naglazyme is indicated for the treatment of patients with mucopolysaccharidosis VI (MPS VI; Maroteaux-Lamy syndrome). Naglazyme has been shown to improve walking and stair-climbing capacity.

### Policy/Criteria

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Naglazyme is **medically necessary** when the following criteria are met:

#### I. Initial Approval Criteria

##### A. Mucopolysaccharidosis VI: Maroteaux-Lamy Syndrome (must meet all):

1. Diagnosis of MPS VI (Maroteaux-Lamy syndrome) confirmed by one of the following (a or b):
  - a. Enzyme assay demonstrating a deficiency in N-acetylgalactosamine 4-sulfatase (arylsulfatase B) activity;
  - b. DNA testing;
2. Age  $\geq$  3 months;
3. Documentation of member's current weight (in kg);
4. Dose does not exceed 1 mg/kg per week.

##### Approval duration:

**Medicaid/HIM** – 6 months

**Commercial** – 6 months or to the member's renewal date, whichever is longer

##### B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or

- b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

## II. Continued Therapy

### A. Mucopolysaccharidosis VI: Maroteaux-Lamy Syndrome (must meet all):

1. Member meets one of the following (a or b):
  - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
  - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Member is responding positively to therapy as evidenced by improvement in the individual member's MPS VI (Maroteaux-Lamy syndrome) manifestation profile (*see Appendix D for examples*);
3. Documentation of member's current weight (in kg);
4. If request is for a dose increase, new dose does not exceed 1 mg/kg per week.

#### Approval duration:

**Medicaid/HIM** – 12 months

**Commercial** – 6 months or to the member's renewal date, whichever is longer

### B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

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**III. Diagnoses/Indications for which coverage is NOT authorized:**

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

FDA: Food and Drug Administration

MPS VI: mucopolysaccharidosis VI

*Appendix B: Therapeutic Alternatives*

Not applicable

*Appendix C: Contraindications/Boxed Warnings*

None reported

*Appendix D: General Information*

The presenting symptoms and clinical course of MPS VI can vary from one individual to another. Some examples, however, of improvement in MPS VI disease as a result of Naglazyme therapy may include improvement in:

- 12-minute walking test distance;
- 3-minute stair climb rate;
- Poor endurance;
- Vision problems;
- Respiratory infections;
- Breathing problems, sleep apnea;
- High blood pressure;
- Joint stiffness;
- Height and weight;
- Hepatomegaly, splenomegaly.

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
MPS VI	1 mg/kg IV once weekly	1 mg/kg/week

**VI. Product Availability**

Vial: 5 mg/5 mL

**VII. References**

1. Naglazyme Prescribing Information. Novato, CA: BioMarin Pharmaceutical, Inc.; December 2019. Available at <http://www.naglazyme.com>. Accessed February 26, 2022.
2. Muenzer J. The mucopolysaccharidoses: a heterogeneous group of disorders with variable pediatric presentations. J Pediatr. 2004; 144(5 Suppl): S27-S34.

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3. Akyol MU, Alden TD, Amartino H, et al. Recommendations for the management of MPS VI: systematic evidence- and consensus-based guidance. *Orphanet J of Rare Dis*, 2019;12(118)1-21.

**Coding Implications**

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J1458	Injection, galsulfase, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2018 annual review: no significant changes from previously approved corporate policy; policies combined for Commercial and Medicaid lines of business; HIM added; Commercial: added diagnosis confirmation testing requirement; added age limit; added specific examples of positive response to therapy for reauthorization; changed approval durations from length of benefit to 6/12 months; references reviewed and updated.	02.26.18	05.18
2Q 2019 annual review: no significant changes; references reviewed and updated.	02.28.19	05.19
2Q 2020 annual review: no significant changes; revised HIM-Medical Benefit to HIM line of business; references reviewed and updated.	02.20.20	05.20
2Q 2021 annual review: no significant changes; revised HIM.PHAR.21 to HIM.PA.154; references reviewed and updated.	02.23.21	05.21
2Q 2022 annual review: no significant changes; added requirement for documentation of member’s current weight for dose calculation purposes; references reviewed and updated.	02.26.22	05.22
Template changes applied to other diagnoses/indications and continued therapy section.	09.30.22	

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health

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plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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**Note: For Medicaid members,** when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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