

Standard Medicare Part B Management Cerezyme

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Cerezyme	imiglucerase

Indications

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-approved Indications¹

Cerezyme is indicated for the treatment of non-central nervous system (CNS) manifestations of Type 1 or Type 3 Gaucher disease in adults and pediatric patients.

Compendial Uses

- Gaucher disease type 2⁶

All other indications will be assessed on an individual basis. Submissions for indications other than those listed in this criteria should be accompanied by supporting evidence from Medicare approved compendia.

Documentation

The following documentation must be available, upon request, for all submissions:

For initial requests: beta-glucocerebrosidase enzyme assay or genetic testing results supporting diagnosis.

Coverage Criteria

Gaucher disease type 1 and 3¹⁻⁵

Authorization of 12 months may be granted for treatment of Gaucher disease type 1 when the diagnosis of Gaucher disease was confirmed by enzyme assay demonstrating a deficiency of beta-glucocerebrosidase (glucosidase) enzyme activity or by genetic testing.

Gaucher disease type 2⁶

Authorization of 12 months may be granted for treatment of Gaucher disease type 2 when the diagnosis of Gaucher disease was confirmed by enzyme assay demonstrating a deficiency of beta-glucocerebrosidase (glucosidase) enzyme activity or by genetic testing.

Continuation of Therapy

All members (including new members) requesting authorization for continuation of therapy must be currently receiving therapy with the requested agent.

Authorization for 12 months may be granted when all of the following criteria are met:

- The member is currently receiving therapy with the requested medication.
- The requested medication is being used to treat an indication in the coverage criteria section.
- The member is receiving benefit from therapy (e.g. improvement in liver volume, spleen volume, hemoglobin concentration, platelet count) and is not experiencing any intolerable adverse events.

Summary Of Evidence

The contents of this policy were created after examining the following resources:

- The prescribing information for Cerezyme.
- The available compendium
 - National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
 - Micromedex DrugDex
 - American Hospital Formulary Service- Drug Information (AHFS-DI)
 - Lexi-Drugs
 - Clinical Pharmacology
- Gaucher disease: GeneReviews
- Revised recommendations for the management of Gaucher disease in children

- Management of neuronopathic Gaucher disease: revised recommendations. European Working Group on Gaucher Disease

After reviewing the information in the above resources, the FDA-approved indications listed in the prescribing information for Cerezyme are covered in addition to the following:

- Gaucher disease type 2

Explanation Of Rationale

Support for FDA-approved indications can be found in the manufacturer's prescribing information.

The diagnosis of Gaucher disease is made when deficient glucocerebrosidase (glucosylceramidase) enzyme activity in peripheral blood leukocytes or other nucleated cells or by the identification of biallelic pathogenic variants in GBA gene (Pastores and Hughes).

Support for using Cerezyme to treat Gaucher disease type 2 can be found in the National Organization for Rare Disorders Guide to Rare Disorders. Enzyme replacement therapy (ERT) is effective for type 1 disease. Anemia and thrombocytopenia improve, hepatomegaly and splenomegaly are reduced, and skeletal damage is ameliorated with ERT. These systemic manifestations also improve with ERT in patients with type 2 and 3 disease. However, it should be noted that ERT does not reverse brain damage in patients with type 2 disease.

References

1. Cerezyme [package insert]. Cambridge, MA: Genzyme Corporation; January 2026.
2. Altarescu G, Hill S, Wiggs E, et al. The efficacy of enzyme replacement therapy in patients with chronic neuronopathic Gaucher's disease. *J Pediatr*. 2001;138:539-547.
3. Erikson A, Forsberg H, Nilsson M, Astrom M, Mansson JE. Ten years' experience of enzyme infusion therapy of Norrbottnian (type 3) Gaucher disease. *Acta Paediatr*. 2006;95:312-317.
4. Pastores GM, Hughes DA. Gaucher Disease. 2000 July 27 [Updated December 7, 2023]. In: Adam MP, Everman DB, Mirzaa GM, et al, editors. *GeneReviews*® [Internet]. Seattle, WA: University of Washington, Seattle; 1993-2023.
5. Kaplan P, Baris H, De Meirleir L, et al. Revised recommendations for the management of Gaucher disease in children. *Eur J Pediatr*. 2013;172:447-458.
6. Gaucher Disease. National Organization for Rare Disorders. (2024). *NORD guide to rare disorders*. Philadelphia: Lippincott Williams & Wilkins.