UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Fabrazyme -ARIZONA

Program	Prior Authorization
Medication	Fabrazyme (agalsidase beta)

1. Background:

Fabrazyme is indicated for use in patients with Fabry disease. Fabrazyme reduces globotriaosylceramide (GL-3) deposition in capillary endothelium of the kidney and certain other cell types.

2. Coverage Criteria:

A. Authorization

1. Fabrazyme will be approved based on the following:

    a. Diagnosis of Fabry disease

Authorization will be issued for 12 months.

3. References:

1. Fabrazyme® Prescribing Information. Genzyme Corporation, May 2010.
2. Eng CM et al. Safety and efficacy of recombinant human alpha galactosidase A replacement therapy in Fabry's disease. N Engl J Med 2001; 345(1) 9-16.
3. Fabry Disease Disease Monograph. Genzyme Corporation, 2001
4. Germain DP, Waldek S, Banikazemi M. et al. Sustained, long-term renal stabilization after 54 Months of agalsidase beta therapy in patients with Fabry disease. J Am Soc Nephrol 2007;18:1547-1557.
5. Banikazemi M, Jan Bultas, Waldek S et al. Agalsidase-beta therapy for advanced Fabry disease. Ann Intern Med. 2007;146:77-86.

Program	Program type – Prior Authorization
Change Control	
Date	Change
August 2017	New policy specific to Arizona