Field Name	Field Description
Prior Authorization Group Description	**Agents to Treat Gaucher's Disease**
Drugs	Cerezyme (imiglucerase), Vpriv (velaglucerase alfa), Elelyso (taliglucerase alfa)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert (PPI).
Exclusion Criteria	None
Required Medical Information	See "Other Criteria"
Age Restrictions	Per package insert
Prescriber Restrictions	Prescriber is a specialist in treatment of Gaucher's Disease (e.g., endocrinologist, hematologist or geneticist), or is in consultation with a specialist
Coverage Duration	If all of the conditions are met, the request will be approved with 6-month duration.
Other Criteria Revision/Review Date 4/2023	**Initial Authorization:** Cerezyme, Vpriv, or Elelyso initial authorization: • Patient has a confirmed diagnosis of Gaucher's disease, type 1 (GD1) Request is for an FDA approved dose **Re-Authorization criteria for all agents:** • Documentation has been provided that patient has obtained clinical benefit from medication (e.g., increased platelet count, improvement in anemia, PFT's, improvement in radiographic scans, improved quality of life) • Request is for an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**