Reference number
2057-A

SPECIALTY GUIDELINE MANAGEMENT

VIMIZIM (elosulfase alfa)

POLICY

I. 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 Indications
Vimizim is indicated for patients with Mucopolysaccharidosis type IVA (MPS IVA, Morquio A syndrome).

All other indications are considered experimental/investigational and are not a covered benefit.

II. REQUIRED DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review: N-acetylgalactosamine 6-sulfatase enzyme assay or genetic testing results supporting diagnosis.

III. CRITERIA FOR INITIAL APPROVAL

Mucopolysaccharidosis IVA (MPS IVA)
Authorization of 12 months may be granted for treatment of MPS IVA when the diagnosis of MPS IVA was confirmed by enzyme assay demonstrating a deficiency of N-acetylgalactosamine 6-sulfatase enzyme activity or by genetic testing.

IV. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for Mucopolysaccharidosis type IVA (MPS IVA, Morquio A syndrome) who are responding to therapy (e.g., improvement, stabilization, or slowing of disease progression for 6-minute walk test [6-MWT]).

V. REFERENCES

1. Vimizim [package insert]. Novato, CA: BioMarin Pharmaceutical Inc.; February 2014.