

Elfabrio® (pegunigalsidase alfa-iwxj) (Intravenous)

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I. Length of Authorization

Coverage will be provided for 12 months and may be renewed.

II. Dosing Limits

A. Quantity Limit (max daily dose) [NDC Unit]:

- Elfabrio 20 mg/10 mL single-dose vial for injection: 6 vials every 14 days

B. Max Units (per dose and over time) [HCPCS Unit]:

- 120 billable units (120 mg) every 14 days

III. Initial Approval Criteria ¹

Coverage is provided in the following conditions:

- Patient is at least 18 years of age; **AND**

Universal Criteria

- Must not be used in combination with migalastat or agalsidase beta; **AND**

Fabry Disease (alpha-galactosidase A deficiency) † ^{1,3,7,13}

- Documented diagnosis of Fabry disease with biochemical/genetic confirmation by one of the following:
 - Deficiency in α -galactosidase A (α -Gal A) activity in plasma, isolated leukocytes, and/or cultured cells (*males only*); **OR**
 - Detection of pathogenic mutations in the *GLA* gene by molecular genetic testing; **AND**
- Patient has a baseline value for at least one of the following:
 - Tissue globotriaosylceramide (Gb3/GL-3) inclusions
 - Plasma or urinary globotriaosylceramide (Gb3/GL-3) or globotriaosylsphingosine (lyso-Gb3)

- Clinical signs and/or symptoms of disease (e.g., dermatologic, gastrointestinal, pulmonary, vascular, renal, cardiac, neurologic manifestations)

† FDA Approved Indication(s); ‡ Compendia Recommended Indication(s); Ⓢ Orphan Drug

IV. Renewal Criteria ^{1,3,13}

Coverage can be renewed based on the following criteria:

- Patient continues to meet the universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: anaphylaxis and severe hypersensitivity reactions, severe infusion-associated reactions, glomerulonephritis, etc.; **AND**
 - Disease response with treatment as defined by a reduction or stabilization in one or more of the following, as compared to pre-treatment baseline:
 - Tissue globotriaosylceramide (Gb3/GL-3) inclusions
 - Plasma or urinary globotriaosylceramide (Gb3/GL-3) or globotriaosylsphingosine (lyso-Gb3); **OR**
 - Disease response with treatment as defined by an improvement or stabilization of clinical signs and/or symptoms (e.g., dermatologic, gastrointestinal, pulmonary, vascular, renal, cardiac, neurologic manifestations)

V. Dosage/Administration ¹

| Indication | Dose |
|---------------|--|
| Fabry Disease | Administer 1 mg/kg (based on actual body weight) by intravenous (IV) infusion every two weeks. |

VI. Billing Code/Availability Information

HCPCS Code:

- J2508 – Injection, pegunigalsidase alfa-iwxj, 1 mg; 1 billable unit = 1 mg

NDC:

- Elfabrio 20 mg/10 mL single-dose vial for injection: 10122-0160-xx

VII. References

1. Elfabrio [package insert]. Parma, Italy; Chiesi Farmaceutici S.p.A.; May 2023. Accessed January 2024.

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7. Kes VB, Cesarik M, Zavoreo I, et al. Guidelines for diagnosis, therapy and follow up of Anderson-Fabry disease. *Acta Clin Croat*. 2013 Sep;52(3):395-405.
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15. Dawn A. Laney, Robin L. Bennett, Virginia Clarke, Angela Fox, Robert J. Hopkin, Jack Johnson, Erin O'Rourke, Katherine Sims, Gerald Walter (2013) Fabry Disease Practice Guidelines: Recommendations of the National Society of Genetic Counselors. Journal of Genetic Counseling, 22(5): 555-564. <https://doi.org/10.1007/s10897-013-9613-3>.

Appendix 1 – Covered Diagnosis Codes

| ICD-10 | ICD-10 Description |
|--------|---------------------------|
| E75.21 | Fabry (-Anderson) disease |

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

The preceding information is intended for non-Medicare coverage determinations. Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determinations (NCDs) and/or Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. Local Coverage Articles (LCAs) may also exist for claims payment purposes or to clarify benefit eligibility under Part B for drugs which may be self-administered. The following link may be used to search for NCD, LCD, or LCA documents: <https://www.cms.gov/medicare-coverage-database/search.aspx>. Additional indications, including any preceding information, may be applied at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD/LCA): N/A

| Medicare Part B Administrative Contractor (MAC) Jurisdictions | | |
|---|---|---|
| Jurisdiction | Applicable State/US Territory | Contractor |
| E (1) | CA, HI, NV, AS, GU, CNMI | Noridian Healthcare Solutions, LLC |
| F (2 & 3) | AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ | Noridian Healthcare Solutions, LLC |
| 5 | KS, NE, IA, MO | Wisconsin Physicians Service Insurance Corp (WPS) |
| 6 | MN, WI, IL | National Government Services, Inc. (NGS) |
| H (4 & 7) | LA, AR, MS, TX, OK, CO, NM | Novitas Solutions, Inc. |
| 8 | MI, IN | Wisconsin Physicians Service Insurance Corp (WPS) |
| N (9) | FL, PR, VI | First Coast Service Options, Inc. |
| J (10) | TN, GA, AL | Palmetto GBA, LLC |
| M (11) | NC, SC, WV, VA (excluding below) | Palmetto GBA, LLC |
| L (12) | DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA) | Novitas Solutions, Inc. |
| K (13 & 14) | NY, CT, MA, RI, VT, ME, NH | National Government Services, Inc. (NGS) |
| 15 | KY, OH | CGS Administrators, LLC |