Drug Coverage Policy

Effective Date.....07/01/2024
Coverage Policy Number.....IP0446
Policy Title.....Miglustat

Gaucher Disease – Substrate Reduction Therapy – Miglustat

- Miglustat capsules
- Yargesa® (miglustat capsules – Edenbridge [generic only])
- Zavesca® (miglustat capsules – Actelion, generic)

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment and have discretion in making individual coverage determinations. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Cigna Healthcare Coverage Policy

Overview
Miglustat capsules (Zavesca, generic), a glucosylceramide synthase inhibitor, is indicated as monotherapy for the treatment of adults with mild to moderate **Gaucher disease type 1** for whom enzyme replacement therapy is not a therapeutic option (e.g., due to allergy, hypersensitivity, or poor venous access).[1]

Disease Overview

Gaucher disease is caused by a deficiency in the lysosomal enzyme β-glucocerebrosidase.[2] This enzyme is responsible for the breakdown of glucosylceramide into glucose and ceramide. In Gaucher disease, deficiency of the enzyme β-glucocerebrosidase results in the accumulation of glucosylceramide substrate in lysosomal compartment of macrophages, giving rise to foam cells or "Gaucher cells." Zavesca is a specific inhibitor of the enzyme glycosylceramide synthase, which is responsible for producing the substrate glucosylceramide.[1] By functioning as a substrate reduction therapy, Zavesca allows the residual activity of the deficient glucocerebrosidase enzyme to be more effective.

Medical Necessity Criteria

Miglustat (miglustat capsules, Yargesa, Zavesca) is considered medically necessary when the following are met:

FDA-Approved Indication

1. **Gaucher Disease Type 1.** Approve for 1 year if the patient meets the following criteria (A, B, and C):
   - **A)** The diagnosis is established by one of the following (i or ii):
     - **i.** Demonstration of deficient beta-glucocerebrosidase activity in leukocytes or fibroblasts; OR
     - **ii.** Molecular genetic testing documenting glucocerebrosidase gene mutation; AND
   - **B)** The medication is prescribed by or in consultation with a geneticist, endocrinologist, metabolic disorder subspecialist, or a physician who specializes in the treatment of Gaucher disease or related disorders.
   - **C)** Preferred product criteria is met for the products listed in the below table(s)

Employer Plans:

Product	Criteria
Zavesca (miglustat)	Trial of **miglustat capsule** (the bioequivalent generic product) AND cannot take due to a formulation difference in the inactive ingredient(s) which would result in a significant allergy or serious adverse reaction

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Conditions Not Covered

Any other use is considered experimental, investigational, or unproven (criteria will be updated as new published data are available).

References

1. Zavesca® capsules [prescribing information]. South San Francisco, CA: Actelion; August 2022.

2. Yargesa® capsules [prescribing information]. Parsippany, NJ: Edenbridge; October 2023.

Revision Details

Type of Revision	Summary of Changes	Date
Selected Revision	**Gaucher Disease Type 1:** Removed criterion related to age, monotherapy and individual's ability to take enzyme replacement therapy. **Updated Employer preferred product criteria.**	07/01/2024

The policy effective date is in force until updated or retired.