Effective Date **1/15/2024**
Next Review Date **1/15/2025**
Coverage Policy Number **IP0446**

Miglustat

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Related Coverage Resources

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. 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.

Overview

This policy supports medical necessity review for the following products:

- miglustat
- Yargesa™ (miglustat)
- Zavesca® (miglustat)

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

Medical Necessity Criteria

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

1. **Gaucher Disease Type 1.** Individual meets **ALL** of the following criteria (A, B, C, D, and E):
   A. Individual is age 18 years or older
   B. Use as monotherapy for mild to moderate disease
   C. There is documentation of **EITHER** of the following (i or ii):

i. Deficiency of glucosylceramidase [also known as acid β-glucosidase or glucocerebrosidase] in peripheral blood leukocytes or other nucleated cells
ii. Confirmation of biallelic pathogenic variants in the *GBA* gene

D. Individual is not a candidate for enzyme replacement therapy (for example, due to allergy, hypersensitivity, or poor venous access)
E. 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.

Coverage varies across plans and requires the use of preferred products. Refer to the customer's benefit plan document for coverage details.

Employer Group Non-Covered Products and the Preferred Covered Alternatives:

Non-Covered Product	Criteria
Zavesca (miglustat)	There is documentation of **ONE** of the following (A or B): A. Continuation of miglustat therapy B. The individual has had an inadequate response, contraindication, or is intolerant to Cerdelga (eliglustat)

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.

Reauthorization Criteria

Miglustat (Zavesca Yargesa) is considered medically necessary for continued use when initial criteria are met AND there is documentation of beneficial response.

Authorization Duration

Initial and reauthorization approval duration: 12 months

Conditions Not Covered

Any other use is considered experimental, investigational or unproven.

Background

OVERVIEW
Miglustat capsules (Zavesca, Yargesa, 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.

References

1. Zavesca capsules [prescribing information]. South San Francisco, CA: Actelion; October 2021.
2. Cerdelga capsules [prescribing information]. Waterford, Ireland: Genzyme; July 2021.