Effective Date: 01/01/2019
Last P&T Approval/Version: 07/28/2021
Next Review Due By: 07/2022
Policy Number: C15445-A

Galafold (migalastat)

PRODUCTS AFFECTED

Galafold (migalastat)

COVERAGE POLICY

Coverage for services, procedures, medical devices, and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.
This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines

Documentation Requirements:
Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive

DIAGNOSIS:
ICD-10: E75.21 Fabry (-Anderson) disease

REQUIRED MEDICAL INFORMATION:
A. FABRY DISEASE:

1. (a) Diagnosis of classic Fabry disease with typical clinical manifestations confirmed by documented deficient α-galactosidase A (α-Gal A) enzyme activity in plasma, isolated leukocytes, and/or cultured cells using alpha galactosidase A enzyme assay (Males with classic Fabry disease have less than 1% α-Gal A enzyme activity, Males with atypical Fabry disease have residual enzyme activity that is greater than 1% of normal) OR Molecular genetic testing that identifies aGLA mutation providing additional confirmation of the diagnosis [Documentation required] OR (b) Diagnosed as a carrier of Fabry disease with significant clinical manifestations, confirmed by documented decrease α-Gal A enzyme activity in plasma and/or isolated leukocytes [Documentation required].
   AND
2. Documentation that member has at least ONE amenable galactosidase alpha (GLA) gene variant based on invitro assay data (see Appendix) [Documentation required].
   AND
3. Prescriber attests (or medical records support) that the member does not currently have severe

renal impairment or end stage renal disease requiring dialysis
AND

4. Documentation of member's baseline disease activity and clinical symptoms
AND
5. Prescriber attests (or medical records support) that the member is not concurrently using enzyme replacement therapy (ERT)(Fabrazyme)
AND
6. Documentation of one of the following:
   a. Member is ERT naïve and is not a candidate for ERT
   OR
   b. Member has ERT-experienced and not able to continue ERT due to non-response after 1 year of therapy, infusion reaction, antibody development, etc.

CONTINUATION OF THERAPY:

A. FABRY DISEASE:
1. Documentation of positive clinical response, or stabilization of disease, to Galafold therapy as documented by: Improvements in GL-3 and/or GL-3 inclusions compared to pre-treatment baseline, OR improvement in clinical symptoms
AND
2. Prescriber attests (or medical records support) that member is not receiving Galafold in combination with Fabrazyme (agalsidase beta)

DURATION OF APPROVAL:
Initial authorization: 12 months, continuing authorization: 12 months

PRESCRIBER REQUIREMENTS:
Prescribed by, or in consultation with, a board-certified Nephrologist, Cardiologist, Neurologist, Endocrinologist, Clinical Geneticist, Clinical Biochemical Geneticist or physician experienced in the management of Fabry disease.

AGE RESTRICTIONS:
18 years of age and older

QUANTITY:
14 capsules/ 28 days

PLACE OF ADMINISTRATION:
The recommendation is that oral medications in this policy will be for pharmacy benefit coverage and patient self-administered.

DRUG INFORMATION

ROUTE OF ADMINISTRATION:
Oral

DRUG CLASS:
Fabry disease agents

FDA-APPROVED USES:
Treatment of adults with a confirmed diagnosis of Fabry disease and an amenable galactosidase alpha gene (GLA) variant based on in vitro assay data

COMPENDIAL APPROVED OFF-LABELED USES:
None

APPENDIX

APPENDIX:
https://www.amicusrx.com/pi/galafold.pdf

Presence of at least one amenable GLA variant (mutation) may be confirmed by the following resources (Galafold prescribing information, 2020):

- Galafold Prescribing Information brochure (package insert; Section 12, Table 2); If aGLA variant is not listed in 'Table 2' of the Galafold Prescribing Information, it is either non-amenable (if tested) or has not been tested for in vitro amenability. If questions, contact Amicus Medical Information at 1-877-4AMICUS or medinfousa@amicusrx.com
- Amicus Fabry GLA Gene Variant Search Tool: http://www.galafoldamenabilitytable.com/hcp

NOTE: Based on available published data, the GLA variant c.937G>T, (p.(D313Y)) is considered benign (not causing Fabry disease). Consultation with a clinical genetics professional is strongly recommended in patients with Fabry disease who have this GLA variant as additional evaluations may be indicated. (Galafold prescribing information, 2020)

BACKGROUND AND OTHER CONSIDERATIONS

BACKGROUND:
ICD-10: E75.21 Fabry (-Anderson) disease Fabry disease is an X-linked lysosomal storage disorder caused by mutations in the GLA gene leading to deficient α- galactosidase A activity, glycosphingolipid accumulation, and life- threatening complications. Phenotypes vary from the "classic" phenotype, with pediatric onset and multi- organ involvement, to later-onset, a predominantly cardiac phenotype. Manifestations are diverse in female members in part due to variations in residual enzyme activity and X chromosome inactivation patterns. Enzyme replacement therapy (ERT) and adjunctive treatments can provide significant clinical benefit. However, much of the current literature reports outcomes after late initiation of ERT, once substantial organ damage has already occurred. Updated monitoring and treatment guidelines for pediatric patients with Fabry disease have recently been published. Expert physician panels were convened to develop updated, specific guidelines for adult patients. Management of adult patients depends on 1) a personalized approach to care, reflecting the natural history of the specific disease phenotype; 2) comprehensive evaluation of disease involvement prior to ERT initiation; 3) early ERT initiation; 4) thorough routine monitoring for evidence of organ involvement in non- classic asymptomatic patients and response to therapy in treated patients; 5) use of adjuvant treatments for specific disease manifestations; and 6) management by an experienced multidisciplinary team.

CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:
All other uses of Galafold (migalastat) are considered experimental/investigational and therefore, will follow Molina's Off-Label policy

OTHER SPECIAL CONSIDERATIONS:
None

CODING/BILLING INFORMATION

Note: 1) This list of codes may not be all-inclusive. 2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement

HCPCS CODE	DESCRIPTION
NA	

AVAILABLE DOSAGE FORMS:
Galafold 123 mg capsule
Packaged as two 7-count capsules blister cards (14 capsules per wallet pack for 28-day supply)

REFERENCES

1. Galafold™ capsules [prescribing information]. Cranbury, NJ: Amicus Therapeutics U.S., Inc.:March 2020.
2. Schiffmann R. Fabry Disease. Handb Clin Neurol. 2015; 132:231-248.
3. Arends M, Wanner C, Hughes D, et al. Characterization of Classical and Nonclassical FabryDisease: A Multinational Study. J Am Soc Nephrol. 2017; 28:1631-1641.
4. Laney DA, Bennett RL, Clarke V, et al. Fabry Disease Practice Guidelines: Recommendations of the National Society of Genetic Counselors. J Genet Counsel. 2013; 22:555-564.
5. Benjamin ER, Della Valle MC, Wu X, et al. The Validation of Pharmacogenetics for the Identification of Fabry Patients to be treated with Migalastat. Genet Med. 2017; 19:430-438.
6. Biegstraaten M, Arngrimsson R, Barbey F, et al. Recommendations for Initiation and Cessation of Enzyme Replacement Therapy in Patients with Fabry Disease: The European Fabry WorkingGroup Consensus Document. Orphanet J Rare Dis. 2015; 10:36 DOI10.1186/s13023-015-0253
7. Laney DA, Bennett RL, Clarke V, et al. Fabry Disease Practice Guidelines: Recommendations of the National Society of Genetic Counselors. J Genet Counsel. 2013; 22:555-564.
8. Warnock DG, Bichet DG, Holida M, et al. Oral Migalastat HCl Leads to Greater Systemic Exposure and Tissue Levels of Active α-Galactosidase A in Fabry Patients when Co-Administered with Infused Agalsidase. PLoS ONE. 2015; 10: e0134341. doi:10.1371/journal.pone.0134341.