POLICY Document for NEXVIAZYME (avalglucosidase alfa-ngpt)

The overall objective of this policy is to support the appropriate and cost-effective use of the medication, specific to use of preferred medication options, lower cost site of care and overall, clinically appropriate use. This document provides specific information to each of the three sections of the overall policy.

Section 1: Site of Care

- Policy information specific to site of care (outpatient, hospital outpatient, home infusion)

Section 2: Clinical Criteria

- Policy information specific to the clinical appropriateness for the medication

Section 1: Site of Care

Site of Care Criteria
Nexviazyme

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated.

Brand Name	Generic Name	Dosage Form
Nexviazyme	avalglucosidase alfa-ngpt	intravenous

Criteria for Approval for Administration in Outpatient Hospital Setting

This policy provides coverage for administration of Nexviazyme in an outpatient hospital setting for up to 106 days when a member is new to therapy or is reinitiating therapy after not being on therapy for at least 6 months.

This policy provides coverage for administration of Nexviazyme in an outpatient hospital setting for a longer course of treatment when ANY of the following criteria are met:

The member has experienced an adverse reaction to the drug that did not respond to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion.

The member has developed laboratory confirmed anti-avalglucosidase alfa-ngpt antibodies which increases the risk for infusion related reactions

The member is medically unstable (e.g., respiratory, cardiovascular, or renal conditions).

The member has severe venous access issues that require the use of special interventions only available in the outpatient hospital setting.

The member has significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver.

Alternative infusion sites (pharmacy, physician office, ambulatory care, etc.) are greater than 30 miles from the member's home.

The member is less than 14 years of age.

For situations where administration of Nexviazyme does not meet the criteria for outpatient hospital infusion, coverage for Nexviazyme is provided when administered in alternative sites such as; physician office, home infusion or ambulatory care.

Required Documentation

The following information is necessary to initiate the site of care prior authorization review (where applicable):

- Medical records supporting the member has experienced an adverse reaction that did not respond to conventional interventions or a severe adverse event during or immediately after an infusion
- Medical records supporting the member has developed anti-avalglucosidase alfa-ngpt antibodies
- Medical records supporting the member is medically unstable
- Medical records supporting the member has severe venous access issues that requires specialized interventions only available in the outpatient hospital setting
- Medical records supporting the member has behavioral issues and/or physical or cognitive impairment and no access to a caregiver
- Records supporting alternative infusion sites are greater than 30 miles from the member's home
- Medical records supporting the member is new to therapy

Section 2: Clinical Criteria

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Specialty Guideline Management
Nexviazyme

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Nexviazyme	avalglucosidase alfa-ngpt

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 Indication[1]

Nexviazyme is indicated for the treatment of patients 1 year of age and older with late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency).

All other indications are considered experimental/investigational and not medically necessary.

Documentation

Submission of the following information is necessary to initiate the prior authorization review:

- Initial requests: acid alpha-glucosidase enzyme assay or genetic testing results supporting diagnosis.
- Continuation requests: chart notes documenting a positive response to therapy.

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Coverage Criteria

Late-onset Pompe disease[1]

Authorization of 12 months may be granted for treatment of late-onset Pompe disease when all of the following criteria are met:

- Member is 1 year of age or older.
- Diagnosis was confirmed by enzyme assay demonstrating a deficiency of acid alpha-glucosidase enzyme activity or by genetic testing.

Continuation of Therapy

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in Section III who are responding to therapy (e.g., improvement, stabilization, or slowing of disease progression for motor function, walking capacity, respiratory function, or muscle strength).

REFERENCES

SECTION 1

1. Nexviazyme [package insert]. Cambridge, MA: Genzyme Corporation; September 2023.

SECTION 2

1. Nexviazyme [package insert]. Cambridge, MA: Genzyme Corporation; September 2023.