



Division: Pharmacy Policy	Subject: Prior Authorization Criteria
Original Development Date: Original Effective Date: Revision Date:	January 18, 2019  June 16, 2022

## **CEREZYME® (imiglucerase)**

**LENGTH OF AUTHORIZATION:** UP TO ONE YEAR

**REVIEW CRITERIA:**

- Patient must be  $\geq 2$  years of age.
- Must have a documented (in “health conditions” or medical records) diagnosis of Gaucher Disease Type I that results in at least one of the following conditions:
  - anemia
  - thrombocytopenia
  - bone disease
  - hepatomegaly or splenomegaly

**DOSING AND ADMINISTRATION:**

- Refer to product labeling at <https://www.accessdata.fda.gov/scripts/cder/daf/>
- Available as 400 units single-dose vial for reconstitution.