Xenpozyme® (olipudase alfa)
(Intravenous)

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I. Length of Authorization

- Initial: Prior authorization validity will be provided initially for 12 months (365 days).
- Renewal: Prior authorization validity may be renewed every 12 months (365 days) thereafter.

II. Dosing Limits

Max Units (per dose and over time) [HCPCS Unit]:

- 344 billable units every 14 days

III. Initial Approval Criteria [1,6]

Prior authorization validity is provided in the following conditions:

- Females of reproductive potential will have pregnancy status verified prior to start of therapy and will use effective contraception during treatment and for 14 days after the last dose if therapy is discontinued**; AND**
- Member has documented baseline measures of at least one of the following (necessary for renewal):
  - Percent predicted diffusion capacity of the lungs for carbon monoxide (DLco) or other age-appropriate pulmonary function testing
  - Spleen and/or liver volume
  - Plasma lyso-sphingomyelin
  - Platelet count
  - Mean height Z-score and/or skeletal maturation *(pediatric members only)*; **AND**

Universal Criteria [1]

- Will not be used in combination with Aqneursa (levacetylleucine) or Miplyffa (arimoclomol); **AND**
- Documented baseline transaminase (alanine aminotransferase [ALT] and aspartate aminotransferase [AST]) levels within 1 month prior to treatment initiation, within 72 hours prior to any infusion during dose escalation, and periodically throughout therapy; **AND**
- Member should not require invasive ventilatory support OR non-invasive ventilatory support while awake and for >12 hours a day *(Note: Members requiring ventilatory support will be reviewed on a case-by-case basis)*; **AND**

- Therapy will be used to treat non-central nervous system manifestations of disease and member does not have severe, irreversible cognitive impairment; **AND**

  ***NOTE**: Requests for continued therapy in members with severe, irreversible cognitive impairment will be reviewed on a case-by-case basis.*

Acid Sphingomyelinase Deficiency (ASMD) (Niemann-Pick Disease) † Φ [1,6]

- Member has a definitive diagnosis of ASMD as confirmed by the following:
  - Detection of biallelic pathogenic (or likely pathogenic) variants in the *SMPD1* gene by molecular genetic testing; **OR**
  - Deficiency of acid sphingomyelinase enzyme activity <10% of controls as measured in peripheral leukocytes, cultured fibroblasts, or lymphocytes; **AND**
- Member has a clinical diagnosis consistent with Niemann-Pick disease type B (NPD-B) or A/B (NPD-A/B) *(Note: NPD-A [infantile neurovisceral ASMD] has not been studied. Genotype-phenotype correlations as well as signs/symptoms may not be conclusive in infants therefore requests will be evaluated on a case-by-case basis)*

† FDA-Approved Indication(s); ‡ Compendia Recommended Indication(s); Φ Orphan Drug

IV. Renewal Criteria [1,6]

Prior authorization validity can be renewed based on the following criteria:

- Member continues to meet the universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: severe hypersensitivity reactions including anaphylaxis, severe infusion-associated reactions, severely elevated liver transaminases, etc.; **AND**
- Disease response with treatment as defined by improvement or stability from pre-treatment baseline by at least one of the following:
  - Improvement in or stability in the percent predicted diffusion capacity of the lungs for carbon monoxide (DLco) or other age-appropriate pulmonary function testing
  - Improvement in or stability of spleen and/or liver volumes
  - Reduction in plasma lyso-sphingomyelin
  - Improvement in or stability of platelet count
  - Improvement in linear growth progression as measured by mean height Z-scores and/or skeletal maturation assessment *(pediatric members only)*

V. Dosage/Administration [1]

Indication	Dose
Acid Sphingomyelinase Deficiency (ASMD)	Administer Xenpozyme via intravenous infusion every 2 weeks. Treatment with Xenpozyme should always be initiated via a dose escalation regimen *(see below)* followed by a maintenance dose. **Adult Members** ***(≥18 years)*** – First dose (Day 1/Week 0): 0.1 mg/kg – Second dose (Week 2): 0.3 mg/kg – Third dose (Week 4): 0.3 mg/kg – Fourth dose (Week 6): 0.6 mg/kg – Fifth dose (Week 8): 0.6 mg/kg – Sixth dose (Week 10): 1 mg/kg – Seventh dose (Week 12): 2 mg/kg – Eighth dose (Week 14): 3 mg/kg (recommended maintenance dose) **Pediatric Members** ***(0 to <18 years)*** – First dose (Day 1/Week 0): 0.03 mg/kg – Second dose (Week 2): 0.1 mg/kg – Third dose (Week 4): 0.3 mg/kg – Fourth dose (Week 6): 0.3 mg/kg – Fifth dose (Week 8): 0.6 mg/kg – Sixth dose (Week 10): 0.6 mg/kg – Seventh dose (Week 12): 1 mg/kg – Eighth dose (Week 14): 2 mg/kg – Ninth dose (Week 16): 3 mg/kg (recommended maintenance dose) ***Note****: Prior to administration, consider premedicating all members with antihistamines, antipyretics, and/or corticosteroids*
Weight-Based Dosing Information The recommended adult and pediatric dosages of Xenpozyme for the dose escalation and maintenance phases are based on body weight as follows for members with a body mass index (BMI): • Less than or equal to 30, the dosage is based on actual body weight (kg) • Greater than 30, the dosage is based on adjusted body weight (kg). Calculate an adjusted body weight (kg) based on height in meters as described below: o Adjusted body weight (kg) = (actual height in m)^2 x 30	

VI. Billing Code/Availability Information

HCPCS Code:

- J0218 – Injection, olipudase alfa-rpcp, 1 mg; 1 billable unit = 1 mg

NDC(s):

- Xenpozyme 4 mg lyophilized powder for reconstitution in a single-dose vial: 58468-0051-xx
- Xenpozyme 20 mg lyophilized powder for reconstitution in a single-dose vial: 58468-0050-xx

VII. References

1. Xenpozyme [package insert]. Cambridge, MA; Genzyme Corporation; December 2024. Accessed March 2026.
2. Wasserstein M, Lachmann R, Hollak C, et al. A randomized, placebo-controlled clinical trial evaluating olipudase alfa enzyme replacement therapy for chronic acid sphingomyelinase deficiency (ASMD) in adults: One-year results. Genetics in Medicine, vol 24, Iss 7, 2022, 1425-1436. ISSN 1098-3600, https://doi.org/10.1016/j.gim.2022.03.021.
3. Diaz GA, Jones SA, Scarpa M, et al. One-year results of a clinical trial of olipudase alfa enzyme replacement therapy in pediatric patients with acid sphingomyelinase deficiency. Genet Med. 2021 Aug;23(8):1543-1550. Doi: 10.1038/s41436-021-01156-3. Epub 2021 Apr 19.
4. Thurberg BL, Diaz GA, Lachmann RH, et al. Long-term efficacy of olipudase alfa in adults with acid sphingomyelinase deficiency (ASMD): Further clearance of hepatic sphingomyelin is associated with additional improvements in pro- and anti-atherogenic lipid profiles after 42 months of treatment. Mol Genet Metab. 2020 Sep – Oct;131(1-2):245-252. Doi: 10.1016/j.ymgme.2020.06.010. Epub 2020 Jun 24.
5. Wasserstein MP, Diaz GA, Lachmann RH, et al. Olipudase alfa for treatment of acid sphingomyelinase deficiency (ASMD): safety and efficacy in adults treated for 30 months. J Inherit Metab Dis. 2018 Sep;41(5):829-838. Doi: 10.1007/s10545-017-0123-6. Epub 2018 Jan 5.
6. Wasserstein MP, Schuchman EH. Acid Sphingomyelinase Deficiency. In: Adam MP, Bick S, Mirzaa GM, et al., editors. GeneReviews® [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2026. Initial Posting: Dec 7, 2006; Last Update: April 27, 2023. Accessed March 5, 2026. Available from: https://www.ncbi.nlm.nih.gov/books/NBK1370/.

Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist

Non-quantitative treatment limitations (NQTLs) refer to the methods, guidelines, standards of evidence, or other conditions that can restrict how long or to what extent benefits are provided under a health plan. These may include things like utilization review or prior authorization. The utilization management NQTL applies comparably, and not more stringently, to mental health/substance use disorder (MH/SUD) Medical Benefit Prescription Drugs and medical/surgical (M/S) Medical Benefit Prescription Drugs. The table below lists the factors that were considered in designing and applying prior authorization to this drug/drug group, and a summary of the conclusions that Prime's assessment led to for each.

Factor	Conclusion
Indication	Yes: Consider for PA
Safety and efficacy	Yes: Consider for PA
Potential for misuse/abuse	No: PA not a priority
Cost of drug	Yes: Consider for PA

Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
E75.241	Niemann-Pick disease type B
E75.244	Niemann-Pick disease type A/B

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

The preceding information is intended for non-Medicare coverage determinations. Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determinations (NCDs) and/or Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. Local Coverage Articles (LCAs) may also exist for claims payment purposes or to clarify benefit eligibility under Part B for drugs which may be self-administered. The following link may be used to search for NCD, LCD, or LCA documents: https://www.cms.gov/medicare-coverage-database/search.aspx. Additional indications, including any preceding information, may be applied at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD/LCA): N/A

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC