Department:	Pharmacy Management	**Original Approval:**	10/12/2020
Policy No:	PM172	**Last Approval:**	11/14/2025
Policy Title:	Pegvaliase (Palynziq) Clinical Coverage Criteria		
Approved By:	UM Criteria Subcommittee		
Applicable Line(s) of Business:	☐ **Washington Apple Health (Medicaid)** ☐ **Behavioral Health Services Only** ☐ **Apple Health Expansion** ☒ **Medicare Advantage/Special Needs Plan** ☒ **Medicare Advantage Only** ☒ **Cascade Select**		

Required Clinical Documentation for Review

Documentation required to determine medical necessity for Pegvaliase (Palynziq):

- History and/or physical examination notes and relevant specialty consultation notes that address the problem and need for the service
- Diagnosis
- Labs/Diagnostics
- Dosing and duration requested
- Initial/Extended approval
- Medical records from the last 6 months showing the patient's problems, history, prior treatments, response to treatment, imaging and laboratory studies, details of the skilled needs, details of any specific needs related to risk/trauma/cultural etc., assessment and plan
- Prescribed by or in consultation with a specialist, when indicated

Background

Phenylketonuria (PKU) is a rare genetic disorder that affects the metabolism of the amino acid phenylalanine (PHE). The enzyme phenylalanine hydroxylase (PAH) is responsible for breaking down ingested phenylalanine into tyrosine, which leads to the downstream production of necessary neurotransmitters.

Genetic mutations that cause reduced levels of PAH are the most common cause of PKU. Patients with a deficiency of PAH will build up phenylalanine when they eat foods with aspartame or protein. Elevated levels of phenylalanine can cause seizures, intellectual disabilities, brain damage, and other neurological problems. The estimated rate of PKU in the U.S. is about 1 in every 10,000-15,000 births.

The standard of care for PKU treatment is dietary restriction of phenylalanine. Typically, phenylalanine-free protein substitutes are used. If dietary restrictions are not adequate as monotherapy, many patients have success with the oral therapy sapropterin in addition to dietary changes. Pegvaliase-pgpz was approved by the FDA in May 2018 for patients with uncontrolled phenylalanine levels (> 600 µmol/L) on existing management.

Pegvaliase-pqpz may be considered medically necessary when it is used to reduce blood phenylalanine concentrations in adult patients with phenylketonuria who have uncontrolled blood phenylalanine concentrations greater than 600 µmol/L on existing management.

Definitions

PHE: Phenylalanine
PKU: Phenylketonuria

Indications/Criteria

AH-IMC members	***Excluded benefit. Authorization and billing required directly through WA Apple Health Fee For Service only. Call 800-562-3022.***
Cascade Select members	***Continue to criteria for approval below.***
Medicare Members	***Continue to criteria for approval below.***

Coverage of Pegvaliase (Palynziq) is recommended in those who meet the following criteria:

FDA-Approved Indications
Phenylketonuria

Initial therapy- Approve for 6 months if the patient meets ALL of the following criteria:

- **A.** Patient has confirmed diagnosis phenylketonuria (PKU) established by a metabolic specialist; AND
- **B.** Patient has uncontrolled blood phenylalanine (PHE) concentrations greater than 600 µmol/L over the last 6 months prior to starting pegvaliase (Palynziq); AND
- **C.** Treatment with sapropterin (Kuvan) has been ineffective, not tolerated, or is contraindicated
    a. Ineffectiveness is defined as a decrease in blood PHE levels of less than 30% from baseline after one month of treatment; AND
- **D.** Patient is greater than or equal to 18 years of age; AND
- **E.** Palynziq is not to be used in combination with sapropterin (Kuvan)

Patients continuing therapy- Approve for 12 months if the patient meets the following criteria:

A. The blood PHE level has decreased at least 20% from baseline or is less than or equal to 600 µmol/L at the maximum dose of 40 mg/day.

Conditions Not Recommended for Approval

Pegvaliase (Palynziq) has not been shown to be effective, or there are limited or preliminary data or potential safety concerns that are not supportive of general approval for the following conditions.

Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

Special Considerations

None.

Limitations/Exclusions

Please refer to a product line's certificate of coverage for benefit limitations and exclusions for these services:

Line of Business	Link to Member Coverage Documents
Medicare Advantage Plans (Including D-SNP)	https://medicare.chpw.org/ Select the appropriate plan from the "Plans" drop down on the top navigation bar.
Apple Health	https://www.chpw.org/for-members/benefits-and-coverage-imc/
Cascade Select	https://chnwhealthinsurance.chpw.org/member-center/plan-benefits/

List of Appendices

None.

Citations & References

CFR	42 CFR § 438.210	
WAC	284-43-2050	
RCW		
LOB & Contract Citation	☐ **WAHIMC** ☐ **BHSO**	

	☐ **Wraparound**	
	☐ **SMAC**	
	☐ **HH**	
	☐ **AHE**	
	☒ **MA/DSNP**	P&P supports all LOB requirements
	☒ **CS**	P&P supports all LOB requirements
Other Requirements		
NCQA Elements		
References	1) Vockley, Jerry, et al. "Phenylalanine hydroxylase deficiency: diagnosis and management guideline." Genetics in Medicine 16.2 (2014): 188. 2) Thomas J, Levy H, Amato S, et al. Pegvaliase for the treatment of phenylketonuria: Results of a long-term phase 3 clinical trial program (PRISM). Mol Genet Metab. 2018;124 (1):27-38. 3) U.S Food and Drug Administration (FDA). FDA approves a new treatment for PKU, a rare and serious genetic disease. FDA News Release. Silver Spring, MD: FDA; May 24, 2018. 4) Palynziq (pegvaliase-pqpz) prescribing information. BioMarin Pharmaceutical, Novato CA. October 2025. 5) Kuvan® (sapropterin dihydrochloride) prescribing information. BioMarin Pharmaceutical, Novato CA. February 2021. Policy: Pegvaliase-pqpz (Palynziq)) 6) https://rarediseases.info.nih.gov/diseases/7383/phenylketonuria 7 https://ghr.nlm.nih.gov/condition/phenylketonuria 8) HCA Medical Policy No. 30.90.85.50-1 Last Updated 05/17/2019	

Revision History

Revision Date	Revision Description	Revision Made By
09/29/2020	New policy	Jennifer Farley, PharmD
10/12/2020	Approval	UM Committee
09/01/2021	Annual review. Format changes. No criteria changes.	Alan Gabot, PharmD
09/02/2021	Approval	UM Pharmacy Subcommittee
07/06/2022	Annual review. Format changes to LOB (LOB only applies to Medicare and Cascade Select)	Alan Gabot, PharmD

07/07/2022	Approval	UM Pharmacy Subcommittee
05/03/2023	Annual review. No criteria changes.	Alan Gabot, PharmD
05/04/2023	Approval	UM Pharmacy Subcommittee
03/12/2024	Annual review. No criteria changes.	Alan Gabot, PharmD
03/13/2024	Approval	UM Criteria Subcommittee
01/01/2025	Annual review. No criteria changes.	Michael Tom, PharmD
01/08/2025	Approval	UM Criteria Subcommittee
11/02/2025	Annual review. No criteria changes.	Alan Gabot, PharmD
11/14/2025	Approval	UM Criteria Subcommittee