Neighborhood Health Plan OF RHODE ISLAND™

Clinical Medical Policy

Relizorb Enzyme Cartridge (RELiZORB™) - # 075

Last reviewed: 03/16/2022

Benefit Coverage

Covered Benefit for lines of business including:
All lines of business
Excluded from Coverage:
None

Benefit Coverage
Covered Benefit for all lines of business

Overview
RELiZORB™ is a digestive enzyme cartridge containing the enzyme lipase. It aims to mimic the action of pancreatic lipase for use in adults and children (ages 5 years and above) who receive enteral tube feedings. RELiZORB™ hydrolyzes (breaks up) fat molecules in enteral formulas, allowing for absorption of fatty acids and monoglycerides, and improvement in nutritional status in patients with cystic fibrosis who require enteral feeds.

Coverage Determination Criteria:

RELiZORB™ Digestive Enzyme Cartridge may be covered when enteral nutrition is medically necessary, and when the following criteria are met:

1. A recent (within the past 90 days) comprehensive medical history and physical examination has been documented.
2. A written plan of care including monitoring for signs and symptoms of improvement in the member's condition, particularly nutritional status.
3. Enteral nutrition is indicated as the primary source of nutritional support essential for the management of risk factors that impair digestion and has a functioning feeding tube with tube feeds being received on a daily basis.
4. The member is over the age of 5 years old.
5. The member has a diagnosis of Cystic Fibrosis. The prescribing provider is a specialist in CF care. Physician or NP.
6. The member has failed a 6 month trial of standard therapy with Pre and Post feed pancreatic enzyme replacement therapy (PERT).
7. In adults and post-pubertal adolescents, showing involuntary or acute weight loss of greater than or equal to 10 percent of usual body weight during a three-to-six- month period, or body mass index (BMI) below 18.5 kg/m2, with consideration for measurement of BMI in members with chronic immobility for whom height is difficult to measure by using another anthropometric method such as height associated with arm span or ratio of upper body to lower extremity length.
8. For pediatric members < 18 years old, the member's BMI is less than the 50th percentile AND the Height and Weight data shows a reduction of these metrics by growth chart.

Neighborhood Health Plan of RI-910 Douglas Pike, Smithfield, RI 02917. www.nhpri.org. Authorization Line-401-459-6060. Authorization Fax- 401-459-6023

Approval will be made for the first 6 months and then reauthorization will be required every 6 months.

Criteria for Reauthorizations:

A new or updated prior authorization request for enteral nutrition products and RELiZORB™ digestive enzyme cartridge therapy must be submitted to continue use of enteral nutrition products before the expiration of the current prior authorization.
1. Member is continuing on enteral tube feedings
2. Documentation of no decrease in BMI, while maintained on enteral feedings and RELiZORB™ digestive enzyme cartridge therapy

Exclusions

• The member is underweight but has the ability to meet nutritional needs through the use of regular formula or food consumption
• Enteral nutrition products are used as supplements to a normal or regular diet in a member showing no clinical indicators of nutritional risk
• The member has food allergies, lactose intolerance, or dental problems, but has the ability to meet his or her nutritional requirements through an alternative food source comparable in effect and available to the member.
• Enteral nutrition products used for dieting or a weight loss program.
• The member has failed a previous trial of RELiZORB™

***For More information on Coding please reference the Authorization Quick Reference Guide**

Authorization Forms

Please access Prior Authorization forms by visiting Neighborhood's website at www.nhpri.org
1. Go to the section for Providers
2. Click on "Resources & FAQ's"
3. Click on "Medical Management Request Forms"- forms are listed alphabetically by program.

Prior Authorization Forms
For assistance with prior authorizations please contact Clinical Administrative Support at 401-459-6060.
Fax authorization forms to 401-459-6023.
Covered Codes: For information on Coding please reference the Authorization Quick Reference

Disclaimer:

This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's coverage plan; a member's coverage plan will supersede the provisions of this medical policy. For information on member-specific benefits, call member services. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to review and revise this policy for any reason and at any time, with or without notice.

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References:

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