LOUISIANA BLUE

Pancreatic Enzyme Replacement Therapy

Policy # 00981
Original Effective Date: 01/01/2027
Current Effective Date: 01/01/2027

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Investigational or experimental services are not covered. This includes any drug, device, procedure, or service provided under the investigational arm of a clinical trial or clinical study. These services are excluded from coverage under benefits.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider Pancreaze®‡ (pancrelipase lipase, pancrelipase amylase, and pancrelipase protease) and Pertzye®‡ (pancrelipase) to be **eligible for coverage.****

Patient Selection Criteria

Coverage eligibility will be considered for Pancreaze (pancrelipase lipase, pancrelipase amylase, and pancrelipase protease) and Pertzye (pancrelipase) when the patient selection criterion is met:

- Patient has tried and failed (e.g., intolerance or inadequate response) Creon®‡ (pancrelipase) **AND** Zenpep®‡ (pancrelipase lipase, pancrelipase protease, pancrelipase amylase) unless there is clinical evidence or patient history that suggests Creon (pancrelipase) **AND** Zenpep (pancrelipase lipase, pancrelipase protease, pancrelipase amylase) will be ineffective or cause an adverse reaction to the patient.
  (*Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.*)

When Services Are Considered Not Medically Necessary

Based on review of available data, the Company considers the use of Pancreaze (pancrelipase lipase, pancrelipase amylase, and pancrelipase protease) and Pertzye (pancrelipase) when the patient selection criterion is not met to be **not medically necessary.****

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Background/Overview

Creon, Pancreaze, Pertzye, and Zenpep are pancreatic enzyme products indicated for the treatment of exocrine pancreatic insufficiency (EPI) in adult and pediatric patients and are used as pancreatic enzyme replacement therapy (PERT). Pancreatic enzyme products (PEPs) work by helping digest food after it is eaten. The products currently available in the U.S. contain a mixture of porcine-derived amylases, lipases, and proteases. Because these enzymes need to reach the small intestine at about the same time as food, PEPs are taken with meals and snacks. When enough enzyme reaches the small intestine with a meal, fat digestion and absorption are improved. Most pancreatic enzyme products used for EPI, including Creon, Pancreaze, Pertzye, and Zenpep, are formulated as delayed-release capsules. In contrast, Viokace®‡ is formulated as an immediate-release tablet, is indicated only for use in adults, and must be administered with a proton pump inhibitor. Pancreatic enzyme products are dosed based on the amount of lipase units needed, and none of the products are interchangeable. Pancreatic enzyme dosing is individualized and may be adjusted based on the patient's body weight, clinical symptoms, fat content in the diet, and steatorrhea. Dose changes should generally be made gradually, allowing several days between adjustments to assess response.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

Creon, Pancreaze, Pertzye, and Zenpep are indicated for the treatment of exocrine pancreatic insufficiency (EPI) in adult and pediatric patients.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to regulations, other plan medical policies, and accredited national guidelines.

Based on a review of the available data and in the absence of any of the caveats mentioned, there is no advantage of Pancreaze or Pertzye over Creon or Zenpep. The active ingredients in the non-preferred products have not been studied head-to-head versus the preferred products and therefore no superiority claims can be made between preferred and non-preferred products.

Reference

1. Creon [package insert]. North Chicago, IL: AbbVie Inc.; Updated February 2024.
2. Pancreaze [package insert]. Campbell, CA: Vivus LLC; Updated May 2025.
3. Pertzye [package insert]. Bethlehem, PA: Digestive Care, Inc.; Updated February 2024.
4. Viokace [package insert]. Campbell, CA: Vivus LLC; Updated July 2025.
5. Zenpep [package insert]. Chiesi USA, Inc.; Updated July 2025.
6. Whitcomb DC, Buchner AM, Forsmark CE. AGA Clinical Practice Update on the Epidemiology, Evaluation, and Management of Exocrine Pancreatic Insufficiency: Expert Review. Gastroenterology November 2023; 165: 1292–1301.
7. Rx Insights: Gastrointestinal. IPD Analytics. December 2018.

Policy History

Original Effective Date: 01/01/2027
Current Effective Date: 01/01/2027
07/21/2026 Pre Pharmacy and Therapeutics Committee review
07/22/2026 Pharmacy and Therapeutics Committee approval. New Policy
Next Scheduled Review Date: 07/2027

**Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;
B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

‡ Indicated trademarks are the registered trademarks of their respective owners.

NOTICE: If the Patient's health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

NOTICE: If an authorization for an ongoing course of treatment has been provided to a member and the member changes from one health plan to another health plan (e.g., a member moves from carrier A to Louisiana Blue), Louisiana Blue may honor the previous health plan's authorization for the same service under the same type of in-network benefit for a 90-day transition period. Documentation of the authorization for the ongoing course of treatment from the previous health plan must be provided to us by the member or their provider and the services provided for the course of treatment must otherwise be a covered service under the Louisiana Blue health plan. This provision does not apply to medications covered under the plan's pharmacy benefit.