

# Medical Drug Clinical Criteria

**Subject:** Relizorb (immobilized lipase) cartridge

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## Overview

This document addresses the use of Relizorb (immobilized lipase) cartridge for individuals for hydrolyzation of fats when used with enteral nutrition via feeding tube.

Relizorb cartridge is an FDA-approved device that delivers lipase immobilized onto polymeric carrier beads to existing enteral feeding pump tube systems to help individuals digest fats contained in enteral formulas, similar to the function of tablet and capsule formulations of available pancreatic enzyme replacement therapies (PERT). However, unlike other PERT agents, Relizorb does not provide protease or amylase.

Relizorb was studied specifically in individuals with cystic fibrosis, where supplementation with continuous enteral nutrition may be necessary if oral nutrition alone yields suboptimal growth and weight gain.

While the Cystic Fibrosis Foundation included mention of Relizorb in its guidelines for Enteral Tube Feeding for Individuals with Cystic Fibrosis (2016), it does not make any recommendations for or against any specific method of providing PERT. It does, however, state that evaluation of Relizorb's benefits and limits should be considered before use.

Instructions for use of Relizorb warns against use in enteral formulas containing insoluble fiber as it may clog the Relizorb cartridge. The document also recommends monitoring for fibrosing colonopathy, a rare and serious adverse effect associated with use of high-dose PERT in the treatment of those with cystic fibrosis.

## Clinical Criteria

When a drug is being reviewed for coverage under a member's medical benefit plan or is otherwise subject to clinical review (including prior authorization), the following criteria will be used to determine whether the drug meets any applicable medical necessity requirements for the intended/prescribed purpose.

### Relizorb (immobilized lipase) cartridge

Initial requests for Relizorb (immobilized lipase) cartridge may be approved if the following criteria are met:

- I. Individual has a diagnosis of cystic fibrosis; **AND**
- II. Individual has a confirmed history of exocrine pancreatic insufficiency; **AND**
- III. Individual requires enteral tube nutrition for continuous durations of 6 hours or more, and using Relizorb to hydrolyze fats in enteral formula; **AND**
- IV. Individual has continued malabsorption of fats (as evidenced by insufficient weight gain or weight loss) from enteral formula, despite optimizing therapy with pancreatic enzyme replacement therapy (PERT) *tablets* or *capsules* administered orally or via feeding tube (capsules only) (Pertzye 2020, Ferrie 2011, Shileout 2011).

Continuation requests for Relizorb (immobilized lipase) cartridge may be approved if the following criteria are met:

- I. Individual has evidence of stable or increased weight from use of Relizorb; **AND**
- II. Individual continues to require enteral tube nutrition for continuous durations of 6 hours or more.

**Approval Duration:**

Initial request: 6 months

Continuation request: 6 months

Relizorb (immobilized lipase) cartridge may not be approved when the above criteria are not met and for all other indications.

**Quantity Limits****Relizorb (immobilized lipase) cartridge Quantity Limits**

Drug	Limit
Relizorb (immobilized lipase) cartridge	2 cartridges per day

**Coding**

The following codes for treatments and procedures applicable to this document are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

**HCPCS**

B4105 In-line cartridge containing digestive enzyme(s) for enteral feeding, each

**ICD-10 Diagnosis**

E84.0-E84.9 Cystic Fibrosis  
 K86.89 Other specified diseases of pancreas  
 K90.89 Other intestinal malabsorption

**Document History**

Revised: 12/11/2023

**Document History:**

- 12/11/2023 – Annual Review: Updated references. Coding Reviewed: No changes.
- 12/12/2022 – Annual Review: Updated references. Coding Reviewed: Added ICD-10-CM K86.89, K90.89.
- 12/13/2021 – Annual Review: No changes. Coding Reviewed: No changes.
- 05/21/2021 – Selected Review: Add new clinical criteria document for Relizorb (immobilized lipase) cartridge. Coding Reviewed: Added HCPCS B4105, Added E84.0-E84.9, K86.8, K90.8.

**References**

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Federal and state laws or requirements, contract language, and Plan utilization management programs or policies may take precedence over the application of this clinical criteria.

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