

POLICY Document for Zemaira

The overall objective of this policy is to support the appropriate and cost effective use of the medication, specific to use of preferred medication options, lower cost site of care and overall clinically appropriate use. This document provides specific information to each of the three sections of the overall policy.

Section 1: Preferred Product

- Policy information specific to preferred medications

Section 2: Site of Care

- Policy information specific to site of care (outpatient, hospital outpatient, home infusion)

Section 3: Clinical Criteria

- Policy information specific to the clinical appropriateness for the medication

Section 1: Preferred Product

ALPHA1-PROTEINASE INHIBITORS PREFERRED PRODUCT: PROLASTIN-C

I. PLAN DESIGN SUMMARY

This program applies to the alpha₁-proteinase inhibitor products specified in this policy. Coverage for targeted products is provided based on clinical circumstances that would exclude the use of the preferred product and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to all members requesting treatment with a targeted product.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table. Alpha1-Proteinase Inhibitor Products

Preferred	Product(s)
Preferred	<ul style="list-style-type: none"> • Prolastin-C (alpha₁-proteinase inhibitor [human])
Targeted	<ul style="list-style-type: none"> • Aralast NP (alpha₁-proteinase inhibitor [human]) • Glassia (alpha₁-proteinase inhibitor [human]) • Zemaira (alpha₁-proteinase inhibitor [human])

II. EXCEPTION CRITERIA

This program applies to members requesting treatment for an indication that is FDA-approved for the preferred product.

Coverage for a targeted product is provided when the member has had a documented intolerable adverse event to the preferred product, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information.

Section 2: Site of Care

Site of Care Criteria Administration of Intravenous Alpha-1-Antitrypsin Aralast-NP, Glassia, Prolastin-C, Zemaira

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I. CRITERIA FOR APPROVAL FOR ADMINISTRATION IN OUTPATIENT HOSPITAL SETTING

This policy provides coverage for administration of alpha-1-antitrypsin drugs in an outpatient hospital setting for up to 2 doses when a member is new to therapy.

This policy provides coverage for administration of alpha-1-antitrypsin in an outpatient hospital setting for a longer course of treatment when ANY of the following criteria are met:

- A. The member has experienced an adverse reaction that did not respond to conventional interventions (eg, acetaminophen, steroids, diphenhydramine, fluids or other pre-medications) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion.
- B. The member has developed IgA antibodies which increases the risk for infusion related reactions.
- C. The member is medically unstable (eg respiratory, cardiovascular, or renal conditions).
- D. The member has severe venous access issues that require the use of a special intervention.
- E. The member has significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver.
- F. Alternative infusion sites are not available.
- G. The member is less than 21 years of age or 65 years of age or older.

For situations where administration of alpha-1-antitrypsin does not meet the criteria for outpatient hospital infusion, coverage for alpha-1-antitrypsin is provided when administered in alternative sites such as; physician office, home infusion or ambulatory care.

II. REQUIRED DOCUMENTATION

The following information is necessary to initiate the site of care prior authorization review (where applicable):

- A. Medical records supporting the member has experienced an adverse reaction that did not respond to conventional interventions or a severe adverse event during or immediately after an infusion
- B. Medical records supporting the member has developed IgA antibodies
- C. Medical records supporting the member is medically unstable
- D. Medical records supporting the member has severe venous access issues
- E. Medical records supporting the member has behavioral issues and/or physical or cognitive impairment and no access to a caregiver
- F. Records supporting alternative infusion sites are not available

Section 3: Clinical Criteria

SPECIALTY GUIDELINE MANAGEMENT Alpha₁-Proteinase Inhibitors

**ARALAST NP (alpha₁-proteinase inhibitor [human])
GLASSIA (alpha₁-proteinase inhibitor [human])
PROLASTIN-C (alpha₁-proteinase inhibitor [human])
ZEMAIRA (alpha₁-proteinase inhibitor [human])**

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III. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

1. Aralast NP
Chronic augmentation therapy in adults with clinically evident emphysema due to severe congenital deficiency of alpha₁-proteinase inhibitor (alpha₁-antitrypsin deficiency)
2. Glassia
Chronic augmentation and maintenance therapy in adults with clinically evident emphysema due to severe hereditary deficiency of alpha₁-proteinase inhibitor (alpha₁-antitrypsin deficiency)
3. Prolastin-C
Chronic augmentation and maintenance therapy in adults with clinical evidence of emphysema due to severe hereditary deficiency of alpha₁-proteinase inhibitor (alpha₁-antitrypsin deficiency)
4. Zemaira
Chronic augmentation and maintenance therapy in adults with alpha₁-proteinase inhibitor deficiency and clinical evidence of emphysema

All other indications are considered experimental/investigational and not medically necessary.

IV. DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review:

1. Pretreatment serum alpha₁-antitrypsin (AAT) level
2. Pretreatment post-bronchodilation forced expiratory volume in 1 second (FEV₁)
3. AAT protein phenotype

V. CRITERIA FOR INITIAL APPROVAL

Authorization of 12 months may be granted for treatment of emphysema due to alpha₁-antitrypsin (AAT) deficiency when all of the following criteria are met:

1. The member's pretreatment serum AAT level is less than 11 micromol/L (80 mg/dL by radial immunodiffusion or 50 mg/dL by nephelometry).
2. The member's pretreatment post-bronchodilation forced expiratory volume in 1 second (FEV₁) is greater than or equal to 25% and less than or equal to 80% of the predicted value.
3. The member has a documented PiZZ, PiZ (null), or Pi (null, null) phenotype (homozygous) AAT deficiency or other phenotype associated with serum AAT concentrations of less than 11 micromol/L (80 mg/dL by radial immunodiffusion or 50 mg/dL by nephelometry).
4. The member does not have the PiMZ or PiMS phenotype AAT deficiency.

VI. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for continued treatment of emphysema due to alpha₁-antitrypsin (AAT) deficiency when the member is experiencing beneficial clinical response from therapy.

VII. OTHER

Note: If the member is a current smoker, they should be counseled on the harmful effects of smoking on pulmonary conditions and available smoking cessation options.

REFERENCES:

SECTION 1

1. Aralast NP [package insert]. Westlake Village, CA: Baxalta US Inc.; December 2018.
2. Glassia [package insert]. Westlake Village, CA: Baxalta US Inc.; June 2017.
3. Prolastin-C [package insert]. Research Triangle Park, NC: Grifols Therapeutics Inc.; June 2018.
4. Zemaira [package insert]. Kankakee, IL: CSL Behring LLC; April 2019.

SECTION 2

1. Aralast NP [package insert]. Westlake Village, CA: Baxalta US Inc.; September 2015.
2. Glassia [package insert]. Westlake Village, CA: Baxalta US Inc.; June 2017.
3. Prolastin-C [package insert]. Research Triangle Park, NC: Grifols Therapeutics Inc.; September 2017.
4. Zemaira [package insert]. Kankakee, IL: CSL Behring LLC; September 2015.
5. American Thoracic Society/European Respiratory Society statement: standards for the diagnosis and management of individuals with alpha-1 antitrypsin deficiency. *Am J Respir Crit Care Med.* 2003;168:818-900.
6. Marciniuk DD, Hernandez P, Balter M, et al. Alpha-1 antitrypsin deficiency targeted testing and augmentation therapy: a Canadian Thoracic Society clinical practice guideline. *Can Respir J.* 2012;19:109-116.
7. Sandhaus RA, Turino G, Brantly ML, et al. The diagnosis and management of alpha-1 antitrypsin deficiency in the adult. *Chronic Obstr Pulm Dis.* 2016;3(3):668-82.

SECTION 3

1. Aralast NP [package insert]. Westlake Village, CA: Baxalta US Inc.; September 2015.
2. Glassia [package insert]. Westlake Village, CA: Baxalta US Inc.; June 2017.
3. Prolastin-C [package insert]. Research Triangle Park, NC: Grifols Therapeutics Inc.; September 2017.
4. Zemaira [package insert]. Kankakee, IL: CSL Behring LLC; September 2015.
5. American Thoracic Society/European Respiratory Society statement: standards for the diagnosis and management of individuals with alpha-1 antitrypsin deficiency. *Am J Respir Crit Care Med.* 2003;168:818-900.
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