POLICY Document for PROLASTIN-C (alpha1 proteinase inhibitor, human)

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, and overall, clinically appropriate use. This document provides specific information to both 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

CAREFIRST: EXCEPTIONS CRITERIA
ALPHA$_1$-PROTEINASE INHIBITORS

PREFERRED PRODUCTS: ARALAST NP, GLASSIA, ZEMAIRA

Client Requested: The intent of the criteria is to ensure that patients follow selection elements as established by CareFirst.

POLICY
This policy informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

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. Acromegaly Products

	Product(s)
Preferred*	• **Aralast NP** (alpha1 proteinase inhibitor, human) • **Glassia** (alpha1 proteinase inhibitor, human)) • **Zemaira** (alpha1 proteinase inhibitor, human)
Targeted	• **Prolastin-C Liquid** (alpha1 proteinase inhibitor, human)

*: Medications considered formulary or preferred on your plan may still require a clinical prior authorization review

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 member has a documented inadequate response, contraindication, or intolerable adverse event to all of the preferred products

Section 2: Site of Care

CareFirst Site of Care Criteria Alpha-1-Antitrypsin

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated.

Brand Name	Generic Name	Dosage Form
Aralast NP	alpha$_1$-proteinase inhibitor [human]	intravenous
Glassia	alpha$_1$-proteinase inhibitor [human]	intravenous
Prolastin-C	alpha$_1$-proteinase inhibitor [human]	intravenous
Zemaira	alpha$_1$-proteinase inhibitor [human]	intravenous

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 12 days when ANY of the following criteria are met:

- The member is new to therapy or is reinitiating therapy after not being on therapy for at least 6 months.
- The member is switching to an alpha-1-antitrypsin product that he/she has not received before.

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:

- The member has experienced an adverse reaction to the drug that did not respond to conventional interventions (eg, acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or

slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion.
- The member has developed IgA antibodies which increases the risk for infusion related reactions.
- The member is medically unstable (e.g., respiratory, cardiovascular, or renal conditions).
- The member has severe venous access issues that require the use of special interventions only available in the outpatient hospital setting.
- 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.
- Alternative infusion sites (pharmacy, physician office, ambulatory care, etc.) are greater than 30 miles from the member's home.
- The member is less than 14 years of age.

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.

Required Documentation

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

- 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
- Medical records supporting the member has developed IgA antibodies
- Medical records supporting the member is medically unstable
- Medical records supporting the member has severe venous access issues that requires specialized interventions only available in the outpatient hospital setting
- Medical records supporting the member has behavioral issues and/or physical or cognitive impairment and no access to a caregiver
- Records supporting alternative infusion sites are greater than 30 miles from the member's home
- Medical records supporting the member is new to therapy or switching to a new alpha-1-antitrypsin product

Section 3: Clinical Criteria

Specialty Guideline Management
Alpha1-Proteinase Inhibitors

CVS/caremark

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Aralast NP	alpha$_1$-proteinase inhibitor [human]
Glassia	alpha$_1$-proteinase inhibitor [human]
Prolastin-C	alpha$_1$-proteinase inhibitor [human]
Zemaira	alpha$_1$-proteinase inhibitor [human]

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[1-5]

Aralast NP

Chronic augmentation therapy in adults with clinically evident emphysema due to severe congenital deficiency of alpha$_1$-proteinase inhibitor (alpha$_1$-antitrypsin deficiency).

Glassia

Chronic augmentation and maintenance therapy in adults with clinically evident emphysema due to severe hereditary deficiency of alpha1-proteinase inhibitor (alpha1-antitrypsin deficiency).

Prolastin-C

Chronic augmentation and maintenance therapy in adults with clinical evidence of emphysema due to severe hereditary deficiency of alpha$_1$-proteinase inhibitor (alpha$_1$-antitrypsin deficiency).

Zemaira

Chronic augmentation and maintenance therapy in adults with alpha$_1$-proteinase inhibitor deficiency and clinical evidence of emphysema.

Compendial Uses[9]

Acute graft-versus-host disease (GVHD)

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

Documentation

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

Alpha$_1$-proteinase Inhibitor (alpha$_1$-antitrypsin) Deficiency:

- Pretreatment serum alpha$_1$-antitrypsin (AAT) level
- Pretreatment post-bronchodilation forced expiratory volume in 1 second (FEV_1)
- AAT protein phenotype or genotype

Coverage Criteria

Alpha$_1$-proteinase Inhibitor (alpha$_1$-antitrypsin) Deficiency[6-8]

Authorization of 12 months may be granted for treatment of emphysema due to alpha$_1$-antitrypsin (AAT) deficiency when all of the following criteria are met:

- 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).
- 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.
- The member has a documented PiZZ, PiZ (null), or Pi (null, null) (homozygous) AAT deficiency or other phenotype or genotype associated with serum AAT concentrations of less than 11 micromol/L (80 mg/dL by radial immunodiffusion or 50 mg/dL by nephelometry).
- The member does not have the PiMZ or PiMS AAT deficiency.

Acute Graft-Versus-Host Disease (GVHD)[9]

Authorization of 12 months may be granted for the treatment of steroid-refractory acute graft-versus-host disease (GVHD) following hematopoietic stem cell transplantation.

Continuation of Therapy

Alpha$_1$-proteinase Inhibitor (alpha$_1$-antitrypsin) Deficiency

Authorization of 12 months may be granted for continued treatment of emphysema due to alpha$_1$-antitrypsin (AAT) deficiency when the member is experiencing beneficial clinical response from therapy.

Acute Graft-Versus-Host Disease (GVHD)

All members requesting authorization for continuation of therapy must meet all requirements in the coverage criteria.

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]. Lexinton, MA: Baxalta Inc; December 2022.
2. Glassia [package insert]. Lexington, MA: Takeda Pharmaceuticals U.S.A., Inc; September 2023.
3. Prolastin-C Liquid [package insert]. Research Triangle Park, NC: Grifols Therapeutics LLC; May 2020.
4. Zemaira [package insert]. Kankalee, IL: CSL Behring LLC; January 2024

SECTION 2

1. Aralast NP [package insert]. Lexington, MA: Takeda Pharmaceuticals.; March 2023.
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3. Prolastin-C [package insert]. Research Triangle Park, NC: Grifols Therapeutics Inc.; May 2020.
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6. Stoller JK, Fallat R, Schluchter MD, et al. Augmentation therapy with alpha1-antitrypsin: patterns of use and adverse events. Chest. 2003;123(5):1425-1434.

SECTION 3

1. Aralast NP [package insert]. Lexington, MA: Baxalta US Inc.; March 2023.
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8. 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.
9. The NCCN Drugs & Biologics Compendium 2024 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed December 16, 2024.