Clinical Policy: Alpha$_1$-Proteinase Inhibitors (Glassia, Prolastin-C, Zemaira)

Reference Number: AZ.CP.PHAR.94
Effective Date: 01.2020
Last Review Date: 02.23
Line of Business: Arizona Medicaid (AzCH-CCP and Care1st) Revision Log

If reviewing a request for Aralast NP, must use AHCCCS FFS PA criteria: https://www.azahcccs.gov/Resources/Downloads/PharmacyUpdates/FFS_PharmaPriorAuthCriteria.pdf

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
The following alpha$_1$-proteinase inhibitors requiring prior authorization are covered in this policy: Glassia®, Prolastin®-C, Zemaira®.

AHCCCS preferred drugs in this class include: Aralast NP

AHCCCS non-preferred drugs in this class include: Glassia, Prolastin-C, Zemaira.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of Arizona Complete Health-Complete Care Plan and Care1st that Glassia, Prolastin-C, and Zemaira are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Alpha$_1$-Antitrypsin Deficiency (must meet all)**:**

1. Diagnosis of severe congenital deficiency of Alpha1-proteinase inhibitor (Alpha1 antitrypsin deficiency);
2. Age ≥ 18 years;
3. Failure of a 4-week trial of Aralast NP at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
4. Member has clinically evident emphysema;
5. Dose does not exceed 60 mg/kg/week.

Approval duration: 12 months

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): AZ.CP.PMN.53 for Arizona Medicaid.

II. Continued Therapy

A. Alpha$_1$-Antitrypsin Deficiency (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 60 mg/kg/week.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): AZ.CP.PMN.53 for Arizona Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – AZ.CP.PMN.53 for Arizona Medicaid.

B. Immunoglobulin A (IgA) deficiency (IgA level less than 15 mg/dL) with known antibody against IgA.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AAT: alpha1-antitrypsin
Alpha$_1$-PI: alpha$_1$-proteinase inhibitors
COPD: chronic obstructive pulmonary disease
FDA: Food and Drug Administration
FEV$_1$: forced expiratory volume in one second

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): use in IgA deficient patients with known antibodies against IgA and/or a history of anaphylaxis or other severe systemic reaction to alpha$_1$-PI, due to the risk of severe hypersensitivity, including anaphylaxis.
- Boxed warning(s): none reported

Appendix D: General Information

- The American Thoracic Society (ATS) and the European Respiratory Society (ERS) state that alpha$_1$-proteinase inhibitor therapy does not confer benefit in, and is not recommended for, patients who have alpha$_1$-proteinase-associated liver disease.
- The 2016 COPD Foundation's clinical practice guidelines for AAT deficiency in the adult recommend intravenous augmentation therapy for individuals with FEV_1 less than 30% predicted with a weak recommendation with a low quality of evidence, and low value placed on the cost of this therapy. The 2003 ATS-ERS guidelines mirror the COPD Foundation in that evidence of benefit from augmentation therapy is weak in those with severe airflow obstruction.
- Safety and effectiveness in the pediatric population have not been established
- Smoking is an important risk factor for the development of emphysema in patients with AAT deficiency. Both the 2003 ATS and 2016 COPD Foundation AAT guidelines state that smoking cessation is important in this patient population.
- The goal of AAT augmentation is to slow the progression of emphysema/lung function decline. Lung function can be measured with FEV_1, which is most important predictor of survival of patients with emphysema due to AAT deficiency per the 2003 ATS AAT guidelines. Improvement, maintenance, or stabilization in FEV_1 rate of decline is therefore an acceptable example of positive response to therapy.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Emphysema due to AAT deficiency	60 mg/kg IV once weekly	60 mg/kg/week

VI. Product Availability

Drug Name	Availability
Alpha$_1$-proteinase inhibitor, human (Aralast NP)	Single-use vial: 500 mg, 1,000 mg
Alpha$_1$-proteinase inhibitor, human (Glassia)	Single-use vial: 1,000 mg/50 mL
Alpha$_1$-proteinase inhibitor, human (Prolastin-C)	Single-use vial: 1,000 mg (Powder)
	Single-use vial: 500 mg/10 mL, 1,000 mg/20 mL, 4,000 mg/80 mL (Liquid)
Alpha$_1$-proteinase inhibitor, human (Zemaira)	Single-use vial: 1,000 mg, 4,000 mg, 5,000 mg

VII. References

1. Aralast NP Prescribing Information. Westlake Village, CA: Baxter Healthcare Corporation; December 2018. Available at: http://www.shirecontent.com/PI/PDFs/ARALASTNP_USA_ENG.pdf. Accessed November 3, 2022.

2. Glassia Prescribing Information. Negev, Israel: Kamada, Ltd.; March 2022. Available at: http://www.liquidglassia.com. Accessed November 3, 2022.
3. Prolastin-C Powder Prescribing Information. Research Triangle Park, NC: Grifols Therapeutics, Inc.; January 2022. Available at: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=91edab72-c889-470e-8315-1798b5548dca. Accessed November 3, 2022.
4. Prolastin-C Liquid Prescribing Information. Research Triangle Park, NC: Grifols Therapeutics, Inc.; May 2020. Available at: http://www.prolastin.com. Accessed November 3, 2022.
5. Zemaira Prescribing Information. Kankakee, IL: CSL Behring LLC; April 2019. Available at: http://www.zemaira.com. Accessed November 3, 2022.
6. 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(7): 818-900.
7. Sandhaus RA, Turino G, and Brantly ML, et al. The diagnosis and management of alpha-1 antitrypsin deficiency in the adult. *Journal of COPD Foundation*. 2016;3(3):668-682.
8. Cazzola M, MacNee W, Martinez FJ, et al.; American Thoracic Society; European Respiratory Society Task Force on outcomes of COPD. Outcomes for COPD pharmacological trials: from lung function to biomarkers. *Eur Respir J*. 2008;31:416–469.
9. Global Initiative for Chronic Obstructive Lung Disease (GOLD). Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease (2021 Report). Available at: http://www.goldcopd.org. Accessed September 14, 2021.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J0256	Injection, alpha 1 proteinase inhibitor (human), not otherwise specified, 10 mg
J0257	Injection, alpha 1 proteinase inhibitor (human), (Glassia), 10 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy created with direction to AHCCCS preferred products.	01.14.2020	01.2020
Added requirement that member is not an active smoker as supported by both ATS and COPD Foundation AAT guidelines.	08.01.20	07.20
1Q 2021 annual review: no significant changes; references reviewed and updated.	02.09.21	02.21

CLINICAL POLICY
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Reviews, Revisions, and Approvals	Date	P&T Approval Date
Added Care1st logo. Added verbiage to specify that criteria also applies to Care1st.	5.10.21	04.21
1Q 2022 annual review: no significant changes; added 500 mg/10 mL and 4,000 mg/80 mL Prolastin-C vials; references reviewed and updated.	12.22.21	02.22
Effective 10/1: updated policy to remove Aralast NP that is on AHCCCS Fee-For-Service Prior Authorization criteria; updated criteria to align with AHCCCS FFS PA criteria for Aralast NP; added a link to AHCCCS FFS PA criteria	09.11.22	10.22
1Q 2023 annual review: no significant changes; references reviewed and updated.	02.03.22	02.23

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan

retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.