

Clinical Policy: Alpha-1 Proteinase Inhibitors (Aralast NP, Glassia, Prolastin-C, Zemaira)

Reference Number: CP.PHAR.94

Effective Date: 03.01.12

Last Review Date: 02.18

Line of Business: Commercial, HIM*, Medicaid

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

The following are alpha-1 proteinase inhibitors requiring prior authorization: alpha1-proteinase inhibitor, human (Aralast[™] NP, Glassia[®], Prolastin[®]-C, Zemaira[®]).

**For Health Insurance Marketplace (HIM), Glassia is non-formulary and cannot be approved using these criteria; refer to the formulary exception policy, HIM.PA.103.*

FDA Approved Indication(s)

Aralast NP, Glassia, Prolastin-C, and Zemaira are indicated for chronic augmentation and maintenance therapy in adults with clinical evidence of emphysema due to severe congenital deficiency of alpha1-PI (alpha-1 antitrypsin [AAT] deficiency). Alpha1-PI products increase antigenic and functional (anti-neutrophil elastase capacity) serum levels and antigenic lung epithelial lining fluid levels of alpha1-PI.

Limitations of use:

- The effect of augmentation therapy with alpha1-PI products on pulmonary exacerbations and on the progression of emphysema in alpha1-PI deficiency has not been conclusively demonstrated in randomized, controlled clinical trials.
- Clinical data demonstrating the long-term effects of chronic augmentation and maintenance therapy of individuals with alpha1-PI products are not available.
- Alpha1-PI products are not indicated as therapy for lung disease in patients in whom severe alpha1-PI deficiency has not been established.

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 health plans affiliated with Centene Corporation[®] that Aralast NP, 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 AAT deficiency;
2. Age \geq 18 years;
3. Member meets one of the following (a or b):

- a. Documentation of plasma AAT level < 11 micromol/L (approximately 50 mg/dL using nephelometry or 80 mg/dL by radial immunodiffusion);
 - b. If member has an AAT level >11 umol/L, then the member must have one of the high-risk phenotypes (i.e. PiZZ, PiZnull, Pi(null, null), or one of a few rare phenotypes [e.g. Pi(Malton, Malton)].
4. Prescribed by or in consultation with a pulmonologist;
 5. Clinical evidence of emphysema (a or b):
 - a. Forced expiratory volume in one second (FEV₁) from ≥ 30% to < 65% of predicted, post-bronchodilator;
 - b. FEV₁ from ≥ 65% to < 80% of predicted, post-bronchodilator, and a rapid decline in lung function showing a change in FEV₁ > 100 mL/year;
 6. Dose does not exceed 60 mg/kg/week.

Approval duration:

Medicaid/Commercial - 6 months

HIM - Aralast NP, Prolastin-C or Zemaira for 6 months (*Refer to HIM.PA.103 for Glassia*)

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): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for 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:

Medicaid/Commercial - 12 months

HIM - Aralast NP, Prolastin-C or Zemaira for 6 months (*Refer to HIM.PA.103 for Glassia*)

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 6 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): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for 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 –

CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage document;

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

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AAT: alpha-1 antitrypsin

Alpha-1 PI: alpha-1 proteinase inhibitors

COPD: chronic obstructive pulmonary disease

FDA: Food and Drug Administration

FEV1: forced expiratory volume in one second

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: 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 FEV1 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.

V. Dosage and Administration

| Drug Name | Indication | Dosing Regimen | Maximum Dose |
|--|---------------------------------|-------------------------|---------------|
| alpha1-proteinase inhibitor, human (Aralast NP) | Emphysema due to AAT deficiency | 60 mg/kg IV once weekly | 60 mg/kg/week |
| alpha1-proteinase inhibitor, human (Glassia) | | | |
| alpha1-proteinase inhibitor, human (Prolastin-C) | | | |
| alpha1-proteinase inhibitor, human (Zemaira) | | | |

VI. Product Availability

| Drug Name | Availability |
|--|----------------------------------|
| alpha1-proteinase inhibitor, human (Aralast NP) | Single-use vial: 500 mg, 1000 mg |
| alpha1-proteinase inhibitor, human (Glassia) | Single-use vial: 1000 mg/50 mL |
| alpha1-proteinase inhibitor, human (Prolastin-C) | Single-use vial: 1000 mg |
| alpha1-proteinase inhibitor, human (Zemaira) | Single-use vial: 1000 mg |

VII. References

1. Aralast NP Prescribing Information. Westlake Village, CA: Baxter Healthcare Corporation; September 2015. Available at http://www.shirecontent.com/PI/PDFs/ARALASTNP_USA_ENG.pdf. Accessed November 20, 2017.
2. Glassia Prescribing Information. Negev, Israel: Kamada, Ltd.; June 2016. Available at <http://www.liquidglassia.com>. Accessed November 20, 2017.
3. Prolastin-C Prescribing Information. Research Triangle Park, NC: Grifols Therapeutics, Inc.; August 2016. Available at <http://www.prolastin.com>. Accessed November 20, 2017.
4. Zemaira Prescribing Information. Kankakee, IL: CSL Behring LLC; September 2015. Available at <http://www.zemaira.com>. Accessed November 20, 2017.
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(7): 818-900.
6. 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.
7. 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.

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 Aralast NP; Prolastin-C; Zemaira |
| J0257 | Injection, alpha 1 proteinase inhibitor (human), (Glassia), 10 mg |

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|--|-------|-------------------|
| Duration of approval has been changed to 12 months | 03.13 | |
| Description updated based on Caremark guideline document | 04.13 | 04.13 |
| Converted to Centene policy template | 06.13 | |
| atReviewed with only minor language changes | 03.14 | 03.14 |
| References reviewed and updated | 02.15 | 03.15 |
| Corrected FEV1 range from 35 to 65% to 30 to 65% based on Table 9 in the 2003 ATS/ERS AAT guidelines | 08.15 | |
| Policy converted to new template. Criteria: added max dose and attestation that member is receiving additional supportive measures per COPD guidelines. | 02.16 | 03.16 |
| Initial criteria: Age removed; conditions representing potential contraindications to therapy are removed. | 02.17 | 03.17 |

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|---|----------|-------------------|
| <p>1Q18 annual review:</p> <ul style="list-style-type: none"> - Combined existing policies for Medicaid and commercial business - Medicaid: removed requirement for supportive measures (avoidance of cigarette smoking and vaccinations) due to lack of actionability and objectivity; - Medicaid: protective threshold value per nephelometry changed from 57 mg/dL to 50 mg/dL per American Thoracic Society 2003 guidelines. - Medicaid: added “If the member has an AAT level >11 umol/L, then the member must have one of the high-risk phenotypes (i.e. PiZZ, PiZnull, Pi(null, null), or one of a few rare phenotypes [e.g. Pi(Malton, Malton)]” to allow treatment before clinical deterioration due to definite diagnosis; - Added prescriber requirement due to the complexity of disease diagnosis and management; - Changed minimally significant change in FEV from 120 mL to 100 mL per ATC guidelines and specialist feedback -References reviewed and updated. | 12.05.17 | 02.18 |

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.

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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.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.

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