Clinical Policy: Alpha-1 Proteinase Inhibitors (Aralast NP, Glassia, Prolastin-C, Zemaira)
Reference Number: ERX.SPA.87
Effective Date: 03.01.14
Last Review Date: 08.17
Line of Business: Commercial [Prescription Drug Plan]

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

Description
Alpha-1 proteinase inhibitors [alpha1-PI] (Aralast™ NP, Glassia®, Prolastin®-C, Zemaira®) inhibit serine proteases such as neutrophil elastase, which is capable of degrading protein components of the alveolar walls and which is chronically present in the lung.

FDA approved indication
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-P1 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 (which may include office chart notes and lab results) supporting that member has met all approval criteria

It is the policy of health plans affiliated with Envolve Pharmacy Solutions™ 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 ≥ 18 years;
      3. Plasma AAT level is < 11 micromol/L (approximately 57 mg/dL using nephelometry or 80 mg/dL by radial immunodiffusion);
      4. 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 > 120 mL/year;
      5. Member is being managed with the following supportive measures per chronic obstructive pulmonary disease (COPD) guidelines (a and b):
         a. Avoidance of cigarette smoking;
         b. Supportive care measures that may include use of bronchodilators, inhaled or oral glucocorticoids, oxygen, pulmonary rehabilitation, nutritional support, lower respiratory tract infection management, and preventive vaccinations;
6. Dose does not exceed 60 mg/kg/week.
   **Approval duration: 6 months**

B. **Other diagnoses/indications**
   1. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III
      (Diagnoses/Indications for which coverage is NOT authorized)

II. **Continued Therapy**
   A. **Alpha-1 Antitrypsin Deficiency** (must meet all):
      1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions or
         member has previously met all initial approval criteria;
      2. Member is responding positively to therapy;
      3. Member is being managed with the following supportive measures per COPD guidelines (a and b):
         a. Avoidance of cigarette smoking;
         b. Supportive care measures that may include use of bronchodilators, inhaled or oral
            glucocorticoids, oxygen, pulmonary rehabilitation, nutritional support, lower respiratory
            tract infection management, and preventive vaccinations;
      4. 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 a health plan affiliated with Envolve Pharmacy Solutions
         and documentation supports positive response to therapy.
         **Approval duration: Duration of request or 6 months (whichever is less); or**
      2. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III
         (Diagnoses/Indications for which coverage is NOT authorized)

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 policy – ERX.PA.01 or
      evidence of coverage documents

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**
   N/A

V. **Dosage and Administration**

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aralast NP</td>
<td>60 mg/kg IV once weekly</td>
<td>60 mg/kg/week</td>
</tr>
<tr>
<td>Glassia</td>
<td></td>
<td></td>
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<tr>
<td>Prolastin-C</td>
<td></td>
<td></td>
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<tr>
<td>Zemaira</td>
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</tr>
</tbody>
</table>

VI. **Product Availability**

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aralast NP</td>
<td>Single-use vial: 500 mg, 1000 mg</td>
</tr>
<tr>
<td>Glassia</td>
<td>Single-use vial: 1000 mg/50 mL</td>
</tr>
<tr>
<td>Prolastin-C</td>
<td>Single-use vial: 1000 mg</td>
</tr>
<tr>
<td>Zemaira</td>
<td>Single-use vial: 1000 mg</td>
</tr>
</tbody>
</table>
VII. References


<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy created</td>
<td>02/14</td>
<td>03/14</td>
</tr>
<tr>
<td>Modified initial approval duration from 12 months to 6 months. Corrected FEV1 range from 35 to 65% to 30 to 65% based on Table 9 in the 2003 ATS/ERS AAT guidelines. Added max dose criteria and attestation that member is receiving additional supportive measures per COPD guidelines.</td>
<td>07/16</td>
<td>09/16</td>
</tr>
<tr>
<td>Converted to new template. Clarified criteria surrounding supportive measures into 2 different subbullets.</td>
<td>06/17</td>
<td>08/17</td>
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</table>

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.

This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. 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.

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