# GEORGIA MEDICAID FEE-FOR-SERVICE
## ENZYME INHIBITORS, SYSTEMIC PA SUMMARY

<table>
<thead>
<tr>
<th>Preferred</th>
<th>Non-Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aralast-NP (alpha-1 proteinase inhibitor [human] intravenous solution)</td>
<td>n/a</td>
</tr>
<tr>
<td>Glassia (alpha-1 proteinase inhibitor [human] intravenous solution)</td>
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<tr>
<td>Prolastin-C (alpha-1 proteinase inhibitor [human] intravenous solution)</td>
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<tr>
<td>Zemaira (alpha-1 proteinase inhibitor [human] intravenous solution)</td>
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<tr>
<td>Zokinvy (lonafarnib)</td>
<td></td>
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</tbody>
</table>

**LENGTH OF AUTHORIZATION:** 1 year

**NOTES:**

- **The criteria details below are for the outpatient pharmacy program.** If a medication is being administered in a physician’s office or clinic, then the medication must be billed through the DCH physician services program and not the outpatient pharmacy program. Information regarding the physician services program is located at [www.mmis.georgia.gov](http://www.mmis.georgia.gov).
- All agents require prior authorization (PA).

**PA CRITERIA:**

**Aralast-NP, Glassia, Prolastin-C and Zemaira**

- Approvable for members 18 years of age or older with a diagnosis of congenital deficiency of alpha-1 proteinase inhibitor (alpha-1 antitrypsin deficiency) confirmed by genetic testing of alleles associated with alpha-1 antitrypsin deficiency (AATD) with clinically evident emphysema
  
  **AND**
  
  - Members must have an alpha-1 antitrypsin (AAT) plasma level less than 11 umol/L and a forced expiratory volume in one second (FEV₁) of 30-65% of predicted or a documented rate of decline in FEV₁.
  - Medication must be administered in member’s home or in a long-term care facility.
  - Medication must be prescribed by or in consultation with a pulmonologist or specialist in alpha-1 antitrypsin deficiency.

**Zokinvy**

- Approvable for members 1 year or older with a body surface area (BSA) of 0.39 m² or greater and a diagnosis of
  
  - Hutchinson-Gilford Progeria Syndrome (HGPS) confirmed by genetic testing of G608G (c.1824C>T[p.Gly608Gly]) pathogenic variant in the *LMNA* gene
  
  **OR**
Processing-deficient Progeroid Laminopathies confirmed by genetic testing of heterozygous LMNA mutation with progerin-like protein accumulation or homozygous or compound heterozygous ZMPSTE24 mutations

**AND**
- Member must have at least one of the following clinical characteristics
  - failure to thrive in the first year of life
  - characteristic facial appearance with micrognathia, prominent eyes and circumoral cyanosis
  - alopecia and prominent scalp veins
  - sclerotic skin changes with outpouching and dimpling/mottling especially on the abdomen
  - decreased joint range of motion and joint contracture.

- Medication must be prescribed by or in consultation with a geneticist, metabolic disorder specialist or progeria specialist.

**EXCEPTIONS:**
- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling OptumRx at 1-866-525-5827.

**PREFERRED DRUG LIST:**
- For online access to the Preferred Drug List (PDL), please go to [http://dch.georgia.gov/preferred-drug-lists](http://dch.georgia.gov/preferred-drug-lists).

**PA AND APPEAL PROCESS:**
- For online access to the PA process, please go to [www.dch.georgia.gov/prior-authorization-process-and-criteria](http://www.dch.georgia.gov/prior-authorization-process-and-criteria) and click on Prior Authorization (PA) Request Process Guide.

**QUANTITY LEVEL LIMITATIONS:**
- For online access to the current Quantity Level Limits (QLL), please go to [www.mmis.georgia.gov/portal](http://www.mmis.georgia.gov/portal), highlight Pharmacy and click on Other Documents, then select the most recent quarters QLL list.