Clinical Policy: Alpha-1 Proteinase Inhibitors (Aralast NP, Glassia, Prolastin-C, Zemaira)
Reference Number: CP.PHAR.94
Effective Date: 03/12
Last Review Date: 03/17

Coding Implications
Revision Log

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

Description
The intent of the criteria is to ensure that patients follow selection elements established by Centene® clinical policy for alpha-1 proteinase inhibitor (human) (Aralast NP™, Glassia®, Prolastin®-C, Zemaira®).

Policy/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 alpha-1 antitrypsin (AAT) deficiency;
         a. Plasma AAT level is < 11 micromol/L (approximately 57 mg/dL using nephelometry or 80 mg/dL by radial immunodiffusion);
      2. 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;
      3. 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 (LRTI) management and preventive vaccinations;
      4. Prescribed dose does not exceed 60 mg/kg once weekly.

   Approval Duration: 6 months

   B. Other diagnoses/indications: Refer to CP.PHAR.57 - Global Biopharm Policy.

II. Continued Approval
   A. Alpha-1 Antitrypsin Deficiency (must meet all):
      1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
      2. Documentation supports positive response 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, LRTI management and preventive vaccinations;
4. Prescribed dose does not exceed 60 mg/kg once weekly.

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; or
   2. Refer to CP.PHAR.57 - Global Biopharm Policy.

Background
Description/Mechanism of Action:
Aralast NP, Glassia, Prolastin-C, and Zemaira are purified human alpha-1 proteinase inhibitors. Alpha-1 antitrypsin (AAT) is the principle protease inhibitor in serum. Its major physiologic role is to render proteolytic enzymes (secreted during inflammation) inactive. A decrease in AAT, as seen in congenital AAT deficiency, leads to increased elastic damage in the lung, causing emphysema.

Formulations:
Intravenous solution:
   Glassia: 1000 mg/50 mL (1 ea)
Reconstituted intravenous solution:
   Zemaira: 1000 mg (1 ea)
   Aralast NP: 500 mg (1 ea); 1000 mg (1 ea)
   Prolastin-C: 1000 mg (1 ea)

FDA Approved Indications:
Aralast NP, Glassia, Prolastin-C, and Zemaira are alpha-1 proteinase inhibitors*/injectable products indicated for:
• Chronic augmentation and maintenance therapy in individuals with clinically evident emphysema due to severe congenital AAT deficiency.

*Also known as alpha-1 PI, alpha-1 antitrypsin, AAT

Limitations of use:
• The effect of augmentation therapy with alpha-1 proteinase inhibitors on pulmonary exacerbations and on the progression of emphysema in alpha-1 proteinase inhibitor deficiency has not been demonstrated in randomized, controlled clinical trials.
• Clinical data demonstrating the long-term effects of chronic augmentation or maintenance therapy of individuals with alpha-1 proteinase inhibitors are not available.
• Alpha-1 proteinase inhibitors are not indicated as therapy for patients with lung disease in whom congenital alpha-1 proteinase inhibitor deficiency has not been established.

Appendices
Appendix A: Abbreviation Key
AAT: alpha-1 antitrypsin
Alpha-1 PI: alpha-1 proteinase inhibitor
FEV₁: forced expiratory volume in one second
IgA: immunoglobulin A
LRTI: lower respiratory tract infection

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.

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<tr>
<th>HCPCS Codes</th>
<th>Description</th>
<th>Date</th>
<th>Approval Date</th>
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<tr>
<td>J0256</td>
<td>Injection, alpha 1-proteinase inhibitor (human), not otherwise specified, 10 mg Aralast NP; Prolastin-C; Zemaira</td>
<td>03/13</td>
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<tr>
<td>J0257</td>
<td>Injection, alpha 1 proteinase inhibitor (human), (Glassia), 10 mg</td>
<td>03/13</td>
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Reviews, Revisions, and Approvals

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<tr>
<th>Description</th>
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<tr>
<td>Duration of approval has been changed to 12 months</td>
<td>03/13</td>
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<tr>
<td>Description updated based on Caremark guideline document</td>
<td>04/13</td>
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<tr>
<td>Converted to Centene policy template</td>
<td>06/13</td>
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<tr>
<td>atReviewed with only minor language changes</td>
<td>03/14</td>
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<tr>
<td>References reviewed and updated</td>
<td>02/15</td>
<td>03/15</td>
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<td>Corrected FEV₁ range from 35 to 65% to 30 to 65% based on Table 9 in the 2003 ATS/ERS AAT guidelines</td>
<td>08/15</td>
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<td>Policy converted to new template. Criteria: added max dose and attestation that member is receiving additional supportive measures per COPD guidelines</td>
<td>02/16</td>
<td>03/16</td>
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<td>Initial criteria: Age removed; conditions representing potential contraindications to therapy are removed.</td>
<td>02/17</td>
<td>03/17</td>
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References


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.

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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.

**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at [http://www.cms.gov](http://www.cms.gov) for additional information.

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