

Alpha-1-Proteinase Inhibitors: Aralast NP®; Glassia®; Prolastin®-C; Zemaira® (Intravenous)

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I. Length of Authorization

Coverage will be provided for 12 months and may be renewed, unless otherwise specified.

- Graft Versus Host Disease (GVHD): Coverage will be provided for a maximum of 8 doses (4 weeks) and may NOT be renewed.

II. Dosing Limits

A. Quantity Limit (max daily dose) [NDC Unit]:

- Aralast NP 1 g/50 mL vial: 7 vials per week
- Aralast NP 0.5 g/25 mL vial: 1 vial per week
- Glassia 1 g/50 mL single use vial: 7 vials per week
- Prolastin-C 1 g/20 mL single-dose vial: 7 vials per week
- Prolastin-C Liquid 1g/20 mL single-dose vial: 7 vials per week
- Zemaira 1 g/20 mL single-use vial: 3 vials per week
- Zemaira 4 g/76 mL single-use vial: 1 vial per week
- Zemaira 5 g/95 mL single-use vial: 1 vial per week

B. Max Units (per dose and over time) [HCPCS Unit]:

Emphysema due to alpha-1-antitrypsin (AAT) deficiency

- 700 billable units every 7 days

GVHD

- 700 billable units for a total of 8 doses in 28 days

III. Initial Approval Criteria ¹⁻⁵

Site of care specialty infusion program requirements are met (refer to [Moda Site of Care Policy](#)).

Coverage is provided in the following conditions:

- Patient is at least 18 years of age; **AND**

Universal Criteria ¹⁻⁵

- Patient does not have immunoglobulin-A (IgA) deficiency with antibodies against IgA; **AND**

Emphysema due to alpha-1-antitrypsin (AAT) deficiency † (Φ – orphan designation applies only to Prolastin-C) ^{1-6,8,9,12,16}

- Patient has an FEV₁ in the range of 30-65% of predicted; **AND**
- Patient has alpha-1-antitrypsin (AAT) deficiency with PiZZ, PiZ (null), or Pi (null, null) phenotypes; **AND**
- Patient has clinical evidence of panacinar/panlobular emphysema; **AND**
- Patient has low serum concentration of AAT ≤ 57 mg/dL (measured by nephelometry) or ≤ 11 μM/L (measured by ELISA); **AND**
- Patient is not a tobacco smoker; **AND**
- Patient is receiving optimal medical therapy (e.g., comprehensive case management, pulmonary rehabilitation, vaccinations, smoking cessation, self-management skills, etc.)

Graft Versus Host Disease (GVHD) ‡ ¹³⁻¹⁵

- Patient has received a hematopoietic stem cell transplant; **AND**
- Used for steroid-refractory acute GVHD; **AND**
- Used in combination with systemic corticosteroids as additional therapy following no response to first-line therapy options

† FDA Approved Indication(s); ‡ Compendia Recommended Indication(s); Φ Orphan Drug

IV. Renewal Criteria ¹⁻⁵

Coverage can be renewed based upon the following criteria:

- Patient continues to meet universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: severe hypersensitivity reactions, etc.; **AND**

Emphysema due to alpha-1-antitrypsin (AAT) deficiency ^{1-6,8,9}

- Disease response with treatment as defined by elevation of AAT levels above baseline, substantial reduction in rate of deterioration of lung function as measured by percent predicted FEV₁, or improvement in CT scan lung density

Graft Versus Host Disease (GVHD) ¹³⁻¹⁵

- Coverage may not be renewed

V. Dosage/Administration ^{1-5,15}

Indication	Dose
Emphysema due to AAT deficiency	Administer 60 mg/kg intravenously once every 7 days (weekly)
GVHD	Administer 60 mg/kg intravenously on days 1, 4, 8, 12, 16, 20, 24, and 28 for up to 4 consecutive weeks (maximum, 8 doses)

VI. Billing Code/Availability Information

HCPCS Code(s) & NDC(s):

Drug	Manufacturer	HCP CS code	1 Billable Unit	SDV Size	NDC
Aralast NP (powder)	Baxalta Inc.	J0256	10 mg	1 g/50 mL	00944-2815-xx
				0.5 g/25 mL	00944-2814-xx
Glassia (solution)	Takeda Pharmaceuticals USA Inc.	J0257	10 mg	1 g/50 mL	00944-2884-xx
Prolastin-C (powder)	Grifols Therapeutics LLC	J0256	10 mg	1 g/20 mL	13533-0700-xx
					13533-0701-xx
					13533-0702-xx
					13533-0703-xx
					13533-0706-xx
Prolastin-C Liquid (solution)	Grifols Therapeutics LLC	J0256	10 mg	500 mg/10 mL	13533-0705-xx
				1 g/20 mL	
				4 g/80 mL	
Zemaira (powder)	CSL Behring LLC	J0256	10 mg	1 g/20 mL	00053-7201-xx
				4 g/76 mL	00053-7202-xx
				5 g/95 mL	00053-7203-xx

VII. References

1. Glassia [package insert]. Lexington, MA; Takeda Pharmaceuticals USA, Inc.; September 2023. Accessed March 2024.
2. Zemaira [package insert]. Kankakee, IL; CSL Behring LLC; January 2024. Accessed March 2024.
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9. Marciniuk DD, Hernandez P, Balter M, et al. Alpha-1 antitrypsin deficiency targeted testing and augmentation therapy: a Canadian Thoracic Society clinical practice guideline. *Can Respir J*. 2012;19(2):109-16.
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12. Miravittles M, Dirksen A, Ferrarotti I, et al. European Respiratory Society statement: diagnosis and treatment of pulmonary disease in α 1-antitrypsin deficiency. *Eur Respir J* 2017; 50.
13. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) for Alpha1-Proteinase Inhibitor (Human). National Comprehensive Cancer Network, 2024. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc.” To view the most recent and complete version of the Compendium, go online to NCCN.org. Accessed March 2024.
14. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) Hematopoietic Cell Transplantation (HCT). Version 3.2023. National Comprehensive Cancer Network, 2024. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc.” To view the most recent and complete version of the Compendium, go online to NCCN.org. Accessed March 2024.
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Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
D89.810	Acute graft-versus-host disease
D89.812	Acute on chronic graft-versus-host disease
D89.813	Graft-versus-host disease, unspecified
E88.01	Alpha-1-antitrypsin deficiency
T86.09	Other complications of bone marrow transplant

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

The preceding information is intended for non-Medicare coverage determinations. Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determinations (NCDs) and/or Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. Local Coverage Articles (LCAs) may also exist for claims payment purposes or to clarify benefit eligibility under Part B for drugs which may be self-administered. The following link may be used to search for NCD, LCD, or LCA documents: <https://www.cms.gov/medicare-coverage-database/search.aspx>. Additional indications, including any preceding information, may be applied at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD/LCA): N/A

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	Applicable State/US Territory	Contractor
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC