MEDICAL MUTUAL®

Drug Policy

Policy:	Zokinvy (lonfarnib)	Annual Review Date: 12/21/2023 Last Revised Date: 12/21/2023

OVERVIEW

Zokinvy is a farnesyltransferase inhibitor indicated in patients 12 months of age and older with a body surface area of 0.39 m^2 and above to reduce the risk of mortality in Hutchinson-Gilford Progeria syndrome (HGPS) and for the treatment of processing-deficient Progeroid Laminopathies (PLs) with either heterozygous LMNA mutation with progerin-like protein accumulation or homozygous or compound heterozygous ZMPSTE24 mutations. Zokinvy is NOT indicated for other Progeroid Syndromes or processing-proficient Progeroid Laminopathies. Based on the mechanism of action, Zokinvy would not be expected to be effective in these populations. Zokinvy is contraindicated in patients taking strong or moderate CYP3A inhibitors or inducers, midazolam, lovastatin, simvastatin, or atorvastatin. Zokinvy is the first FDA-approved therapy for the treatment of HGPS and processing-deficient PLs. Limited clinical trial data evaluated the use of pravastatin and zoledronic acid, but use of these agents is not endorsed or recommended by any guidelines or organizations.

POLICY STATEMENT

This policy involves the use of Zokinvy. Prior authorization is recommended for pharmacy benefit coverage of Zokinvy. Approval is recommended for those who meet the conditions of coverage in the **Criteria and Initial/Extended Approval** for the diagnosis provided. **Conditions Not Recommended for Approval** are listed following the recommended authorization criteria. Requests for uses not listed in this policy will be reviewed for evidence of efficacy and for medical necessity on a case-by-case basis.

Because of the specialized skills required for evaluation and diagnosis of patients treated with Zokinvy as well as the monitoring required for adverse events and long-term efficacy, initial approval requires Zokinvy be prescribed by or in consultation with a physician who specializes in the condition being treated. All approvals for initial therapy are provided for the initial approval duration noted below; if reauthorization is allowed, a response to therapy is required for continuation of therapy unless otherwise noted below.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Zokinvy is recommended in those who meet the following criteria:

1. **Hutchinson-Gilford Progeria Syndrome (HGPS)**
   Criteria. *Patient must meet the following criteria*
   - **A.** The patient is 12 months of age or older; AND
   - **B.** The patient has a body surface area (BSA) of 0.39 m^2 or greater; AND

C. Zokinvy is prescribed by or in consultation with a specialist in progeria, genetics, and/or metabolic disorders; AND
D. The patient has known causative pathogenic variant in the LMNA gene [documentation required]

2. <u>Processing-Deficient Progeroid Laminopathies (PLs)</u>
Criteria. *Patient must meet the following criteria*

A. The patient is 12 months of age or older; AND
B. The patient has a body surface area (BSA) of 0.39 m^2 or greater; AND
C. Zokinvy is prescribed by or in consultation with a specialist in progeria, genetics, and/or metabolic disorders; AND
D. The patient meets one of the following [documentation required]:
  a. Heterozygous LMNA mutation with progerin-like protein accumulation; OR
  b. Homozygous or compound heterozygous ZMPSTE24 mutations

3. <u>Continuation of Zokinvy therapy</u>
Criteria. *Patient must meet the following criteria*

A. The patient is tolerating therapy; AND
B. The patient has experienced a beneficial response to therapy, as determined by the prescribing physician; AND
C. The prescribed dosage is appropriate for the patient's BSA; AND
D. Zokinvy is prescribed by or in consultation with a specialist in progeria, genetics and/or metabolic disorders

Initial Approval/ Extended Approval.
A) *Initial Approval:* 1 year
B) *Extended Approval:* 1 year

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Zokinvy has not been shown to be effective, or there are limited or preliminary data or potential safety concerns that are not supportive of general approval for the following conditions. (Note: This is not an exhaustive list of Conditions Not Recommended for Approval).

1. **Concurrent use with strong or moderate CYP3A inhibitors or inducers, midazolam, lovastatin, simvastatin, or atorvastatin.** Use of Zokinvy in combination with these agents in contraindicated per FDA-approved labeling.

2. **Other Progeroid Syndromes.** Zokinvy is not indicated for use in other progeroid syndromes. Based on its mechanism of action, Zokinvy would not be expected to be effective in this population.

3. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the drug provided or services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

REFERENCES

1. Zokinvy [prescribing information]. Palo Alto, CA: Eiger BioPharmaceuticals, Inc.; November 2020.
2. Introne WJ, Merideth MA. Hutchinson-Gilford progeria syndrome. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate, Inc. https://www.uptodate.com/contents/hutchinson-gilford-progeria-syndrome. Accessed 9 December 2020.
3. Lonafarnib. In: DRUGDEX [online database]. Truven Health Analytics; Greenwood Village, CO. Last updated 18 May 2021. Accessed 14 December 2021.