curative

Zokinvy Prior Authorization Drug List A

Drug(s) Applied:	**Zokinvy** (lonafarnib)

Criteria:
Drug(s) Applied will be approved when the requested medication is being used for an FDA approved indication and all of the following criteria are met:

I. Initial Therapy Criteria

A. Hutchinson-Gilford progeria syndrome (HGPS) as indicated by chart notes within past 90 days

1. Genetic testing has confirmed a pathogenic variant in the LMNA gene that results in production of progerin (medical record required) **and**
2. Patient has a body surface area (BSA) of greater than or equal to 0.39m^2 **and**
3. Patient's age is 12 months or older **and**
4. Prescriber is a specialist in the area of the patient's diagnosis (e.g., cardiology, geneticist) **and**
5. Chart notes and/or prescriber do not provide documentation of concurrent use of strong CYP3A inhibitors, strong or moderate CYP3A inducers, midazolam, lovastatin, simvastatin, or atorvastatin, or prescriber has documented that the benefits outweigh the risk despite having a contraindication

Approval Duration: 4 months

B. Processing-deficient progeroid laminopathy as indicated by chart notes within past 90 days

1. ONE of the following:
   a) Genetic testing has confirmed heterozygous LMNA mutation with progerin-like protein accumulation (medical record required) **or**
   b) Genetic testing has confirmed homozygous or compound heterozygous ZMPSTE24 mutations (medical record required) **and**
2. Patient has a body surface area (BSA) of greater than or equal to 0.39m^2 **and**
3. Patient's age is 12 months or older **and**
4. Prescriber is a specialist in the area of the patient's diagnosis (e.g., cardiology, geneticist) **and**
5. Chart notes and/or prescriber do not provide documentation of concurrent use of strong CYP3A inhibitors, strong or moderate CYP3A inducers, midazolam, lovastatin, simvastatin, or atorvastatin, or prescriber has documented that the

benefits outweigh the risk despite having a contraindication

Approval Duration: 4 months

II. Continued Therapy Criteria

A. Hutchinson-Gilford progeria syndrome (HGPS) or Processing-deficient progeroid laminopathy as indicated by chart notes within past 12 months

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization process or meets the initial therapy criteria above **and**
2. Patient has a body surface area (BSA) of greater than or equal to 0.39m^2 **and**
3. **and**
4. Prescriber is a specialist in the area of the patient's diagnosis (e.g., cardiology, geneticist) **and**
5. Chart notes and/or prescriber do not provide documentation of concurrent use of strong CYP3A inhibitors, strong or moderate CYP3A inducers, midazolam, lovastatin, simvastatin, or atorvastatin, or prescriber has documented that the benefits outweigh the risk despite having a contraindication

Approval Duration: 12 months

Policy Owned by: Curative PBM team