LifeWise
Health Plan of Washington

MEDICAL POLICY – 5.01.624

Alpha-1 Proteinase Inhibitors

Effective Date:	**Jan. 3, 2025***	RELATED MEDICAL POLICIES:
Last Revised:	Sept. 10, 2024	11.01.523 Site of Service: Infusion Drugs and Biologic Agents
Replaces:	N/A	
*Click here to view the current policy.		

Select a hyperlink below to be directed to that section.

POLICY CRITERIA | DOCUMENTATION REQUIREMENTS | CODING
RELATED INFORMATION | EVIDENCE REVIEW | REFERENCES | HISTORY

∞ Clicking this icon returns you to the hyperlinks menu above.

Introduction

Alpha$_1$-antitrypsin (AAT) deficiency is a rare, inherited disease that is caused by a change (mutation) in the SERPINA1 gene. The SERPINA1 gene provides instructions to create alpha$_1$-antitrypsin which prevents the destruction of elastin in the lungs, liver, and skin. In the lungs this elastin deficiency can cause early onset chronic obstructive pulmonary disease (COPD) (i.e., emphysema). Cigarette smoke can rapidly accelerate damage to the lungs in individuals with AAT deficiency. Standard treatment includes exercise programs, nutritional support, drugs, and avoidance of cigarette smoke. When the AAT deficiency becomes severe drugs called alpha$_1$-proteinase inhibitors can be used to increase the AAT levels which may slow the decline in lung function and delay any further damage. There are currently four Food and Drug Administration (FDA) approved alpha$_1$-proteinase inhibitors available which are Aralast NP, Glassia, Prolastin-C, and Zemaira. This policy describes when drugs used to treat emphysema due to severe AAT deficiency may be considered medically necessary.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

We will review specific intravenous (IV) and injectable drugs for medical necessity for all ages.

For those age 13 and older, we also will review the site of service for medical necessity. Site of service is defined as the location where the drug is administered, such as a hospital-based outpatient setting, an infusion center, a physician's office, or at home. Click **here** to be directed to the site of service review criteria.

Drugs subject to site of service review addressed in this policy are:

- **First-line products:**
  - Aralast NP (alpha$_1$-proteinase inhibitor [human]) IV
  - Prolastin-C (alpha$_1$-proteinase inhibitor [human]) IV
  - Zemaira (alpha$_1$-proteinase inhibitor [human]) IV
- **Second-line product:**
  - Glassia (alpha1-proteinase inhibitor [human]) IV

Site of Service Administration	Medical Necessity
Medically necessary sites of service • **Physician's office** • **Infusion center** • **Home infusion**	**IV infusion therapy of various medical or biologic agents will be covered in the most appropriate, safe and cost-effective site:** • These are the preferred **medically necessary** sites of service for specified drugs.
Hospital-based outpatient setting • **Outpatient hospital IV infusion department** • **Hospital-based outpatient clinical level of care**	**IV infusion therapy of various medical or biologic agents will be covered in the most appropriate, safe and cost-effective site.** **This site is considered medically necessary for the first 90 days for the following:** • The initial course of infusion of a pharmacologic or biologic agent

Site of Service Administration	Medical Necessity
	OR • Re-initiation of an agent after 6 months or longer following discontinuation of therapy* **Note:** *This does not include when standard dosing between infusions is 6 months or longer **This site is considered medically necessary when there is no outpatient infusion center within 50 miles of the individual's home and there is no contracted home infusion agency that will travel to their home, or a hospital is the only place that offers infusions of this drug.** **This site is considered medically necessary only when the individual has a clinical condition which puts him or her at increased risk of complications for infusions, including any ONE of the following:** • Known cardiac condition (e.g., symptomatic cardiac arrhythmia) or pulmonary condition (e.g., significant respiratory disease, serious obstructive airway disease, %FVC ≤ 40%) that may increase the risk of an adverse reaction • Unstable renal function which decreases the ability to respond to fluids • Difficult or unstable vascular access • Acute mental status changes or cognitive conditions that impact the safety of infusion therapy • A known history of severe adverse drug reactions and/or anaphylaxis to prior treatment with a related or similar drug
Hospital-based outpatient setting • **Outpatient hospital IV infusion department** • **Hospital-based outpatient clinical level of care**	**These sites are considered not medically necessary for infusion and injectable therapy services of various medical and biologic agents when the site-of-service criteria in this policy are not met.**

Drug	Medical Necessity
Aralast NP (alpha$_1$-proteinase inhibitor [human]) IV • **First-line** **Prolastin-C (alpha$_1$-proteinase inhibitor [human]) IV** • **First-line** **Zemaira (alpha$_1$-proteinase inhibitor [human]) IV** • **First-line**	**Aralast NP (alpha$_1$-proteinase inhibitor (PI) [human]), Prolastin-C (alpha$_1$-PI [human]), and Zemaira (alpha$_1$-PI [human]) may be considered medically necessary for the treatment of adult individuals with clinically evident emphysema due to severe hereditary deficiency of alpha$_1$-PI (alpha$_1$-antitrypsin deficiency) when the following criteria are met:** • Individual is aged 18 years or older **AND** • Genetic testing documents mutation in the SERPINA1 gene **AND** • Serum alpha$_1$-antitrypsin is less than 11 micromole/L (approximately 57 mg/dL by nephelometry) **AND** • Forced expiratory volume in one second (FEV_1) is 30-65% of predicted **AND** • Individual is receiving treatment for emphysema with a long-acting inhaled bronchodilator and/or corticosteroid **AND** • Individual is a non-smoker or is enrolled in a smoking cessation program **AND** • Medication is prescribed by or in consultation with a pulmonologist or geneticist
Glassia (alpha$_1$-proteinase inhibitor [human]) IV • **Second-line**	**Glassia (alpha$_1$-PI [human]) may be considered medically necessary for the treatment of adult individuals with clinically evident emphysema due to severe hereditary deficiency of alpha$_1$-PI (alpha$_1$-antitrypsin deficiency) when the following criteria are met:** • Individual is aged 18 years or older **AND** • Genetic testing documents mutation in the SERPINA1 gene **AND** • Serum alpha$_1$-antitrypsin is < 11 micromole/L (approximately 57 mg/dL by nephelometry) **AND**

Drug	Medical Necessity
	• Forced expiratory volume in one second (FEV_1) is 30-65% of predicted **AND** • Individual is receiving treatment for emphysema with a long-acting inhaled bronchodilator and/or corticosteroid **AND** • Individual is a non-smoker or is enrolled in a smoking cessation program **AND** • Medication is prescribed by or in consultation with a pulmonologist or geneticist **AND** • Individual has had an inadequate response or intolerance to Aralast NP (alpha1-proteinase inhibitor (PI) [human]), Prolastin-C (alpha1-PI [human]), or Zemaira (alpha1-PI [human])

Drug	Investigational
As listed	**All other uses of the drugs for conditions not outlined in this policy are considered investigational.**

Length of Approval	
Approval	**Criteria**
Initial authorization	**All drugs listed in policy may be approved up to 6 months.**
Re-authorization criteria	**Future re-authorization of all drugs listed in policy may be approved up to 12 months as long as the drug-specific coverage criteria are met and chart notes at the time of re-authorization show:** • An increase from baseline of $alpha_1$-antitrypsin levels **AND** • Slowing of decline in lung function

Documentation Requirements
The individual's medical records submitted for review for all conditions should document that medical necessity criteria are met. The record should include the following:

Documentation Requirements
• Office visit notes that contain the diagnosis, relevant history, physical evaluation, and medication history

Coding

Code	Description
HCPCS	
J0256	Injection, alpha 1-proteinase inhibitor, human, 10 mg, not otherwise specified (Aralast NP, Prolastin-C, Zemaira)
J0257	Injection, alpha 1 proteinase inhibitor (human), (Glassia), 10 mg

Note: CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

Related Information

Consideration of Age

The ages stated in this policy for which Aralast NP, Glassia, Prolastin-C, and Zemaira are considered medically necessary are based on the ages approved in the US Food and Drug Administration (FDA) labeling.

Benefit Application

This policy is managed through the medical benefit.

Evidence Review

Background

Alpha$_1$-antitrypsin (AAT) deficiency is a chronic, autosomal, co-dominant hereditary disorder characterized by reduced levels of AAT in the blood and lungs. Smoking is an important risk factor for the development of emphysema in individuals with AAT deficiency. Because emphysema affects many, but not all individuals with the more severe genetic variants of AAT deficiency, augmentation therapy with alpha$_1$-proteinase inhibitor (human) is indicated only in individuals with severe AAT deficiency who have clinically evident emphysema.

A large number of phenotypic variants of AAT deficiency exist, not all of which are associated with the clinical disease. Approximately 95% of identified AAT deficient individuals have the PiZZ variant, typically characterized by AAT serum levels less than 35% of normal. Individuals with the Pi(null)(null) variant have no AAT protein in their serum. Individuals with the lack of, or low, endogenous serum levels of AAT (i.e., below 11 µM) manifest a significantly increased risk for development of emphysema above the general population background risk. In addition, PiSZ individuals, whose serum AAT levels range from approximately 9 to 23 µM are considered to have moderately increased risk for developing emphysema, regardless of whether their serum AAT levels are above or below 11 µM.

Augmenting the levels of functional protease inhibitor by intravenous infusion is an approach to therapy for individuals with AAT deficiency. However, the efficacy of augmentation therapy in affecting the progression of emphysema has not been demonstrated in randomized, controlled clinical trials. The intended theoretical goal is to provide protection to the lower respiratory tract by correcting the imbalance between neutrophil elastase and protease inhibitors. Whether augmentation therapy with any alpha$_1$-proteinase inhibitor product actually protects the lower respiratory tract from progressive emphysematous changes has not been conclusively demonstrated in adequately powered, randomized controlled clinical trials. Although the maintenance of blood serum levels of AAT (antigenically measured) above 11 µM has been historically postulated to provide therapeutically relevant antineutrophil elastase protection, this has not been proven. Individuals with severe AAT deficiency have been shown to have increased neutrophil and neutrophil elastase concentrations in lung epithelial lining fluid compared to normal PiMM individuals, and some PiSZ individuals with AAT above 11 µM have emphysema attributed to AAT deficiency. These observations underscore the uncertainty regarding the appropriate therapeutic target serum level of AAT during augmentation therapy.

Summary of Evidence

Aralast NP (alpha1-proteinase inhibitor [human])

Description

Aralast NP contains approximately 2% alpha$_1$-PI with truncated C-terminal lysine (removal of Lys394). Aralast NP is a sterile, lyophilized preparation of purified human alpha$_1$-proteinase inhibitor. Aralast NP is prepared from large pools of human plasma by using the cold ethanol fractionation process, followed by purification steps including polyethylene glycol and zinc chloride precipitations and ion exchange chromatography.

Dosage and Administration

Administer 60 mg/kg body weight of Aralast NP once weekly by intravenous infusion. The infusion rate of Aralast NP should not exceed 0.2 mL/kg/min, and as determined by the response and comfort of the individual.

Efficacy

A clinical trial (Aralast versus Prolastin trial) was conducted to compare the predecessor product Aralast to a commercially available preparation of alpha$_1$-PI (Prolastin) in 28 subjects with congenital alpha$_1$-PI deficiency and emphysema, who had not received alpha$_1$-PI augmentation therapy within the preceding six months.

Subjects were randomized to receive either Aralast or Prolastin, 60 mg/kg intravenously per week for 10 consecutive weeks. Following their first 10 weekly infusions, the subjects who were receiving Prolastin were switched to Aralast while those who already were receiving Aralast continued to receive it.

Following weekly augmentation therapy with Aralast or Prolastin, a gradual increase in peak and trough serum alpha$_1$-PI levels was noted, with stabilization after several weeks. The metabolic half-life of Aralast was 5.9 days. Serum anti-neutrophil elastase capacity (ANEC) trough levels rose substantially in all subjects by Week 2, and by Week 3, serum ANEC trough levels exceeded 11 µM in the majority of subjects. With few exceptions, levels in both treatment groups remained above this level in individual subjects for the duration of the period Weeks 3 through 24. Although only five of fourteen subjects (35.7%) receiving Aralast had BALs meeting acceptance criteria for analysis at both baseline and Week 7, a statistically significant increase in

the antigenic level of alpha$_1$-PI in epithelial lining fluid (ELF) was observed. No statistically significant increase in the ANEC in the ELF was detected. It was concluded that at a dose of 60 mg/kg administered intravenously once weekly, Aralast and Prolastin had similar effects in maintaining target serum alpha$_1$-PI trough levels and increasing antigenic levels of alpha$_1$-PI in the ELF with maintenance augmentation therapy.

Adverse Reactions

The most common adverse reactions occurring in greater than or equal to 5% of infusions in clinical studies were headache, musculoskeletal discomfort, vessel puncture site bruise, nausea, and rhinorrhea.

Glassia (alpha1-proteinase inhibitor [human])

Description

Glassia is a sterile, ready to use, liquid preparation of purified human alpha$_1$-proteinase inhibitor (PI). The solution contains 2% active alpha$_1$-PI in a phosphate-buffered saline solution. The specific activity of Glassia is greater than or equal to 0.7 mg functional alpha$_1$-PI per mg of total protein. No less than 90% of the alpha$_1$-PI in Glassia is of the monomeric form as measured by size-exclusion chromatography. Glassia is prepared from human plasma obtained from US-licensed plasma collection centers by a modified version of the cold ethanol fractionation process and the alpha$_1$-PI is then purified using chromatographic methods.

Dosage and Administration

Administer 60 mg/kg body weight of Glassia once weekly by intravenous infusion. The infusion rate of Glassia should not exceed 0.2 mL/kg/min, and as determined by the response and comfort of the individual. The recommended dosage of 60 mg/kg at a rate of 0.2 mL/kg/min will take approximately 15 minutes to infuse.

Efficacy

A randomized, double-blind trial with a partial cross-over was conducted to compare Glassia to a commercially available preparation of alpha$_1$-PI (Prolastin) in 50 alpha$_1$-PI deficient subjects.

The trial objectives were to demonstrate that the pharmacokinetics of antigenic and/or functional alpha$_1$-PI in Glassia were not inferior to those of the control product, to determine whether Glassia maintained antigenic and/or functional plasma levels of at least 11 µM (57 mg/dL) and to compare alpha$_1$-PI trough levels (antigenic and functional) over 6 infusions.

For inclusion in the trial, subjects were required to have lung disease related to alpha$_1$-PI deficiency and 'at-risk' alleles associated with alpha$_1$-PI plasma levels less than 11 µM. Subjects already receiving alpha$_1$-PI therapy were required to undergo a 5-week wash-out period of exogenous alpha$_1$-PI prior to dosing.

Fifty subjects received either Glassia (33 subjects) or the comparator product (17 subjects) at a dose of 60 mg/kg intravenously per week for 12 consecutive weeks. From Week 13 to Week 24 all subjects received open-label weekly infusions of Glassia at a dose of 60 mg/kg.

Trough levels of functional and antigenic alpha$_1$-PI were measured prior to treatment, at baseline and throughout the trial until Week 24. The median trough alpha$_1$-PI values for Weeks 7-12 for subjects receiving Glassia were 14.5 µM (range: 11.6 to 18.5 µM) for antigenic and 11.8 µM (range: 8.2 to 16.9 µM) for functional alpha$_1$-PI. Eleven of 33 subjects (33.3%) receiving Glassia had mean steady-state functional alpha$_1$-PI levels below 11 µM. Glassia was shown to be non-inferior to the comparator product.

Serum alpha$_1$-PI trough levels rose substantially in all subjects by Week 2 and were comparatively stable during Weeks 7 to 12. All subjects receiving Glassia had mean serum trough antigenic alpha$_1$-PI levels greater than 11 µM during Weeks 7-12.

A subset of subjects in both treatment groups (n = 7 for subjects receiving Glassia) underwent broncho-alveolar lavage (BAL) and were shown to have increased levels of antigenic alpha$_1$-PI and alpha1-PI - neutrophil elastase complexes in the epithelial lining fluid at Week 10-12 over levels found at baseline, demonstrating the ability of the product to reach the lung.

The clinical efficacy of Glassia in influencing the course of pulmonary emphysema or the frequency, duration, or severity of pulmonary exacerbations has not been demonstrated in randomized, controlled clinical trials.

Adverse Reactions

The most common adverse reactions (greater than 0.5% of infusions) in clinical trials were headache and upper respiratory infection.

Prolastin-C (alpha1-proteinase inhibitor [human])

Description

Prolastin-C is a sterile, white to beige-colored concentrate of alpha$_1$-PI in lyophilized powder form for reconstitution for intravenous infusion. Each vial contains approximately 1,000 mg of functionally active alpha$_1$-PI as determined by capacity to neutralize porcine pancreatic elastase. The specific activity of Prolastin-C is greater than or equal to 0.7 mg functional alpha$_1$-PI per mg of total protein. Prolastin-C has a purity of greater than or equal to 90% alpha$_1$-PI (alpha$_1$-PI protein/total protein). When reconstituted with 20 mL of Sterile Water for Injection, USP, Prolastin-C has a pH of 6.6–7.4, a sodium content of 100–210 mM, a chloride content of 60–180 mM and a sodium phosphate content of 13–25 mM. Prolastin-C contains no preservative. Prolastin-C is produced from pooled human plasma through modifications of the Prolastin process using purification by polyethylene glycol (PEG) precipitation, anion exchange chromatography, and cation exchange chromatography.

Dosage and Administration

Administer 60 mg/kg body weight of Prolastin-C once weekly by intravenous infusion. The infusion rate of Prolastin-C should not exceed 0.08 mL/kg/min, and as determined by the response and comfort of the individual.

Efficacy

The clinical efficacy of Prolastin-C in influencing the course of pulmonary emphysema or pulmonary exacerbations has not been demonstrated in adequately powered, randomized, controlled clinical trials.

A total of 23 subjects with the PiZZ variant and documented emphysema were studied in a single-arm, open label clinical trial with Prolastin, the predecessor product. Nineteen of the subjects received Prolastin, 60 mg/kg, once weekly for up to 26 weeks (average 24 weeks). Blood levels of alpha$_1$-PI were maintained above 11 µM. Bronchoalveolar lavage studies demonstrated statistically significant increased levels of alpha$_1$-PI and functional anti-neutrophil elastase capacity (ANEC) in the epithelial lining fluid of the lower respiratory tract of the lung, as compared to levels prior to dosing.

Adverse Reactions

The most common adverse reaction during clinical trials in > 5% of subjects was upper respiratory tract infection.

Zemaira (alpha1-proteinase inhibitor [human])

Description

Zemaira is a sterile, white to off-white, lyophilized preparation of purified alpha$_1$-proteinase inhibitor (human) (alpha$_1$-PI), also known as alpha -antitrypsin, to be reconstituted and administered by the intravenous route. The specific activity of Zemaira is greater than or equal to0.7 mg of functional alpha$_1$-PI per milligram of total protein. The purity (total alpha$_1$-PI/total protein) is greater than or equal to90% alpha$_1$-PI. Each vial contains approximately 1000 mg, 4000 mg, or 5000 mg of functionally active alpha$_1$-PI. The measured amount per vial of functionally active alpha$_1$-PI as determined by its capacity to neutralize human neutrophil elastase (NE) is printed on the vial label and carton. Following reconstitution with 20 mL, 76 mL, or 95 mL of Sterile Water for Injection, USP, the Zemaira solution contains 73 to 89 mM sodium, 33 to 42 mM chloride, 15 to 20 mM phosphate, and 121 to 168 mM mannitol. Hydrochloric acid and/or sodium hydroxide may have been added to adjust the pH. Zemaira contains no preservative.

Dosage and Administration

Administer 60 mg/kg body weight of Zemaira once weekly by intravenous infusion. The infusion rate of Zemaira should not exceed 0.08 mL/kg/min, and as determined by the response and comfort of the individual. The recommended dosage of 60 mg/kg body weight will take approximately 15 minutes to infuse.

Efficacy

Clinical trials were conducted pre-licensure with Zemaira in 89 subjects (59 males and 30 females). The subjects ranged in age from 29 to 68 years (median age 49 years). Ninety-seven percent of the treated subjects had the PiZZ phenotype of alpha$_1$-PI deficiency, and 3% had the M phenotype. At screening, serum alpha$_1$-PI levels were between 3.2 and 10.1 µM (mean of 5.6 µM). The objectives of the clinical trials were to demonstrate that Zemaira augments and

maintains serum levels of alpha$_1$-PI above 11 µM (80 mg/dL) and increases alpha$_1$-PI levels in epithelial lining fluid (ELF) of the lower lung.

In a double-blind, controlled clinical trial to evaluate the safety and efficacy of Zemaira, 44 subjects were randomized to receive 60 mg/kg of either Zemaira or Prolastin once weekly for 10 weeks. After 10 weeks, subjects in both groups received Zemaira for an additional 14 weeks. Subjects were followed for a total of 24 weeks to complete the safety evaluation. The mean trough serum alpha$_1$-PI levels at steady state (Weeks 7-11) in the Zemaira-treated subjects were statistically equivalent to those in the Prolastin treated subjects within a range of ±3 µM. Both groups were maintained above 11 µM. The mean (range and standard deviation [SD]) of the steady state trough serum antigenic alpha$_1$-PI level for Zemaira-treated subjects was 17.7 µM (range 13.9 to 23.2, SD 2.5) and for Prolastin-treated subjects was 19.1 µM (range 14.7 to 23.1, SD 2.2). The difference between the Zemaira and the Prolastin groups was not considered clinically significant and may be related to the higher specific activity of Zemaira.

The clinical efficacy of Zemaira or any alpha$_1$-PI product in influencing the course of pulmonary emphysema or pulmonary exacerbations has not been demonstrated in adequately powered, randomized, controlled clinical trials.

Adverse Reactions

The most common adverse reactions occurring in at least 5% of subjects in all pre-licensure clinical trials were headache, sinusitis, upper respiratory infection, bronchitis, asthenia, cough increased, fever, injection site hemorrhage, rhinitis, sore throat, and vasodilation

2022 Update

Reviewed prescribing information for all drugs listed in policy and information on the management of adults with clinically evident emphysema due to severe hereditary deficiency of alpha$_1$-PI (alpha$_1$-antitrypsin deficiency). No new information was identified that would require changes to this policy.

2023 Update

Reviewed prescribing information for all drugs listed in policy. No new evidence found that would require changes to the policy. Removed trademarks from the brand products for the process of standardization.

2024 Update

Reviewed prescribing information for all drugs listed in policy. Added site of service review for Aralast NP, Glassia, Prolastin-C, and Zemaira.

References

1. Aralast NP (alpha1-proteinase inhibitor (PI) [human]) Prescribing Information. Baxalta US Inc., Lexington, MA. Revised March 2023.
2. Glassia (alpha1-proteinase inhibitor (PI) [human]) Prescribing Information. Baxalta US Inc., Lexington, MA. Revised September 2023.
3. Prolastin-C (alpha1-proteinase inhibitor (PI) [human]) Prescribing Information. Grifols Therapeutics LLC, Research Triangle Park, NC. Revised May 2020.
4. Zemaira (alpha1-proteinase inhibitor (PI) [human]) Prescribing Information. CSL Behring LLC, Kankakee, IL. Revised September 2022.
5. Stoller J. Treatment of alpha-1 antitrypsin deficiency. UpToDate. Available at: **https://www.uptodate.com/contents/treatment-of-alpha-1-antitrypsin-deficiency**. Accessed June 18, 2024.
6. Stoller J. Clinical manifestations, diagnosis, and natural history of alpha-1 antitrypsin deficiency. UpToDate. Available at: **https://www.uptodate.com/contents/clinical-manifestations-diagnosis-and-natural-history-of-alpha-1-antitrypsin-deficiency**. Accessed June 18, 2024.
7. Stoller J, Aboussouan L. A review of α1-antitrypsin deficiency. Am J Respir Crit Care Med 2012; 185:246.
8. Global Initiative for Chronic Obstructive Lung Disease (GOLD). Global Strategy for the Diagnosis, Management and Prevention of chronic obstructive pulmonary disease: 2018 Report. **http://www.goldcopd.org**. Accessed on June 18, 2024.

History

Date	Comments
06/01/21	New policy, approved May 11, 2021, effective for dates of service on or after September 3, 2021, following 90-day provider notification. Add to Prescription Drug section. Added criteria for Aralast NP (alpha$_1$-proteinase inhibitor (PI) [human]), Glassia (alpha$_1$-PI [human]), Prolastin-C (alpha$_1$-PI [human]), and Zemaira (alpha$_1$-PI [human]) for the treatment of emphysema due to severe alpha$_1$-antitrypsin deficiency. Added HCPC code J0256 for Aralast NP, Prolastin-C, Zemaira and HCPC code J0257 for Glassia.
01/01/23	Annual Review, approved December 23, 2022. No changes to policy statements. Changed the wording from "patient" to "individual" throughout the policy for standardization.
09/01/23	Annual Review, approved August 7, 2023. Reviewed prescribing information for all drugs listed in policy. No new evidence found that would require changes to the policy.
08/01/24	Annual Review, approved July 9, 2024. The following policy changes are effective November 1, 2024, following 90-day provider notification. Added site of service review for Aralast NP, Glassia, Prolastin-C, and Zemaira.
10/01/24	Interim Review, approved September 10, 2024. The following policy changes are effective January 3, 2025, following a 90-day provider notification. Changed Glassia to a non-preferred product and updated Glassia coverage criteria to require the individual had an inadequate response or intolerance to Aralast NP, Prolastin-C, or Zemaira.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.