HealthPartners

Zokinvy (lonafarnib)

Coverage Criteria:

Zokinvy is reserved for patients meeting the following criteria:

1. Prescribed by pediatric endocrinologist or pediatric geneticist; and,
2. Patients is 12 months or older with BSA >0.39 m2; and,
3. Patient has been diagnosed with one of the following, confirmed with genetic testing, and documented in the medical record:
    a. Hutchinson-Gilford progeria syndrome (HGPS), or;
    b. processing-deficient progeroid laminopathies with either
        i. heterozygous LMNA mutation with progerin-like protein accumulation, or
        ii. homozygous or compound heterozygous ZMPSTE24 mutations; and,
4. Documentation of adequate liver and renal function has been submitted. Adequate hepatic function is as defined as SGPT (ALT) and SGOT (AST) ≤ 5 times upper limit of normal range for age. Adequate renal function is defined as an eGFR>30 ml/min/1.73m2; and,
5. Documented patient weight; and,
6. Zokinvy is being prescribed up to the FDA-approved dosing regimen.

Coverage Duration:

Initial approvals will be granted for 6 months.
Reauthorizations will be granted for 12 months.

Renewal Criteria:

1. Patient continues to meet above criteria; and,
2. Patient has been seen within the past 14 months by the specialist; and,
3. Provider attests that the patient has had a clinically meaningful response to the medication (e.g. documented weight gain compared to baseline).

P&T Date: 4/5/2021
Effective Date: 4/5/2021