SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Zokinvy™ (lonafarnib)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Approval – 1 (ONE) year

1. Is Zokinvy™ prescribed by, or in consultation with, a specialist in genetics or metabolic disorders?
   ❑ Yes ❑ No
2. Is the member 12 months of age or older and does the member have a body-surface area of ≥ 0.39 m^2?
   ❑ Yes ❑ No

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3. Does the member have a diagnosis of one of the following?
   - Hutchinson-Gilford progeria syndrome (HGPS)
     - Member has had a confirmatory mutational analysis with a G608G mutation in the lamin A gene [LMNA gene] (e.g., c.1824C>T)

     OR
   - Processing-deficient progeroid laminopathies
     - Heterozygous LMNA mutation with progerin-like protein accumulation (e.g., pathogenic variant in either the exon 11 splice junction or intron 11 of LMNA gene)
     - Homozygous or compound heterozygous ZMPSTE24 mutations

   ❑ Yes ❑ No
4. Is there confirmation that the member does **NOT** have other non-laminopathy progeroid syndromes or processing-proficient progeroid laminopathies or laminopathies with no progeria features (mutation in the LMNA gene with no clinical characteristic features)? ❑ Yes ❑ No
5. Does the member have at least one of the following clinical features suggestive of progeria?
   - Profound failure to thrive during the first year of life; **OR**
   - Characteristic facial appearance (e.g., micrognathia, prominent eyes, circumoral cyanosis); **OR**
   - Sclerodermatous skin changes (e.g., taut, thickened, fibrotic, indurated, rippled); **OR**
   - Alopecia or prominent scalp veins; **OR**
   - Decreased joint range of motion and joint contractures; **OR**
   - X-ray findings (e.g., distal clavicular, terminal phalangeal resorption, coxa valga, delayed/incomplete primary tooth eruption); **OR**
   - Severe atherosclerosis and/or cardiac disease (e.g., myocardial infarction, heart failure, cerebrovascular disease [stroke])

   ❑ Yes ❑ No
6. Will the member have periodic ophthalmological examinations during treatment?

   ❑ Yes ❑ No
7. Will the member avoid concomitant therapy with any of the following?
   - Coadministration with midazolam; **AND**
   - Coadministration with HMG-CoA reductase inhibitors other than pravastatin (e.g., lovastatin, simvastatin, atorvastatin); **AND**
   - Coadministration with strong or moderate CYP3A inhibitors (e.g., fluconazole, itraconazole); **AND**
   - Coadministration with strong and moderate CYP3A inducers (e.g., rifampin, carbamazepine, St. John's wort); **AND**
   - Coadministration with strong or moderate CYP2C9 inhibitors (e.g., voriconazole, metronidazole, fluvastatin, sulfamethoxazole), or if therapy is unavoidable, the member will be monitored closely for adverse reaction and/or dose modifications will be implemented

   ❑ Yes ❑ No

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Renewal Approval – 1 (ONE) year. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

1. Does the member continue to meet the above criteria? ❑ Yes ❑ No
2. Has the member experienced a disease response as evidenced by improvement or stabilization, change in the rate of decline, or a decrease in disease progression? ❑ Yes ❑ No
3. Is there confirmation that the member has **NOT** experienced any treatment-restricting adverse effects (e.g., severe laboratory abnormalities, severe nephrotoxicity, severe retinal toxicity)? ❑ Yes ❑ No

Medication being provided by a Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

REVISED/UPDATED/REFORMATTED: ~~8/11/2021;~~ **11/10/2023**