

Clinical Policy Title:	lonafarnib
Policy Number:	RxA.670
Drug(s) Applied:	Zokinvy®
Original Policy Date:	03/09/2021
Last Review Date:	12/11/2025
Line of Business Policy Applies to:	All line of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Hutchinson-Gilford Progeria Syndrome (HGPS) (must meet all):

1. Confirmed diagnosis of HGPS.

Approval Duration

All Lines of Business (except Medicare): 12 months

B. Processing-deficient Progeroid Laminopathies (must meet all):

1. Diagnosis of processing-deficient progeroid laminopathy with one of the following mutations (a or b):
 - a. Heterozygous LMNA mutation with progerin-like protein accumulation
 - b. Homozygous or compound heterozygous ZMPSTE24 mutations.

Approval Duration

All Lines of Business (except Medicare): 12 months

II. Continued Therapy Approval

A. All Indications in Section I (must meet all):

1. Auto-approval based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy.

Approval Duration

All Lines of Business (except Medicare): 12 months

References

1. Hennekam RCM. Hutchinson-Gilford progeria syndrome: review of the phenotype. Am J Med Genet A. 2006;140(23):2603-2624. Available at: <https://pubmed.ncbi.nlm.nih.gov/16838330/>. Accessed August 28, 2024.

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	2/5/2021	3/9/2021
Policy was reviewed: 1. References were reviewed and updated.	12/10/2021	01/17/2022
Policy was reviewed: 1. References were reviewed and	10/21/2022	01/17/2023

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

updated.		
Policy was reviewed.	10/19/2023	10/19/2023
Policy was reviewed: 1. Removed age restrictions. 2. Removed prescriber restrictions. 3. Removed BSA restrictions. 4. Removed dose restrictions. 5. Updated verbiage for diagnosis of processing-deficient progeroid laminopathies. 6. Updated Continued therapy approval with auto-approval based on lookback functionality within the past 120 days. 7. Reauthorization criteria for all the diagnosis merged under “All Indications in Section I”. 8. Removed reauthorization requirement for positive response to therapy. 9. Updated approval duration verbiage. 10. Reference was reviewed and updated.	08/28/2024	9/13/2024
Policy was reviewed.	12/05/2024	N/A
Policy reviewed.	12/11/2025	12/11/2025