

# HealthAlliance**MEDICARE**

## **PURPOSE OF THE POLICY**

To provide prior authorization criteria for Prolastin®.

## **STATEMENT OF THE POLICY**

Health Alliance will approve Prolastin® after appropriate B versus D decisions have been made when the below criteria has been met:

## **PROCEDURES**

### **1. Inclusion Criteria**

- 1.1 All approved FDA indications not otherwise excluded from Part D.
- 1.2 Coverage is limited to Prolastin® Brand.
- 1.3 Dosage 60mg/kg weekly or 250mg/kg monthly.
- 1.4 High risk phenotype.
- 1.5 Plasma AAT level below 11mcmol/L or 80mg/L.
- 1.6 FEV1 greater than or equal to 35 AND
- 1.7 Less than or equal to 65% of predicted.
- 1.8 Age 18 years old or greater