

POLICY NAME	Zokinvy (lonafarnib)	POLICY #	2740P
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Criteria

Coverage Criteria

- ☐ Documented diagnosis of one of the following:
 - Hutchinson-Gilford progeria syndrome
 - Processing-deficient progeroid laminopathies with either: ☐ Heterozygous LMNA mutation with progerin-like protein accumulation ☐ Homozygous or compound heterozygous ZMPSTE24 mutations
- ☐ Member is 12 months or older
- ☐ Member has a Body Surface Area (BSA) $\geq 0.39\text{m}^2$
- ☐ Ordered by, or in consultation with a specialist in progeria, genetics, or metabolic disorders
- ☐ Review of chart notes documenting diagnosis and confirming that patient has met all above requirements for treatment with Zokinvy by both a pharmacist and medical director