Pharmacy Drug Policy Checklist

POLICY NAME	Zokinvy (lonafarnib)	POLICY #	2740P

Criteria

Coverage Criteria

- ☐ **1.1** 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
- ☐ **1.2** Member is 12 months or older
- ☐ **1.3** Member has a Body Surface Area (BSA) ≥ 0.39m2
- ☐ **1.4** Ordered by, or in consultation with a specialist in progeria, genetics, or metabolic disorders
- ☐ **1.5** 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