Division: Pharmacy Policy	Subject: Prior Authorization Criteria
Original Development Date: Original Effective Date: Revision Date:	August 4, 2021

ZOKINVY™ (lonafarnib)

LENGTH OF AUTHORIZATION: Up to one year

INITIAL REVIEW CRITERIA:

- Patient must be 12 months of age and documented BSA ≥ 0.39 m^2.
- Diagnosis of one of the following as confirmed by genetic testing:
  - Hutchinson-Gilford Progeria Syndrome (HGPS)
  - Processing-deficient Progeroid Laminopathy with either
    - Heterozygous *LMNA* mutation with progerin-like protein accumulation

      or
    - Homozygous or compound heterozygous *ZMPSTE24* mutations
- Prescribed by, or in consultation, with a specialist, document specialty type.

CONTINUATION OF THERAPY:

- Patient met initial review criteria.
- Documentation of positive clinical response.
- Dosing is appropriate as per labeling or is supported by compendia.

DOSING AND ADMINISTRATION:

- Refer to product labeling at https://www.accessdata.fda.gov/scripts/cder/daf/
- Dosage Forms: 50 mg and 75 mg capsules