Mass General Brigham
Health Plan

# Alpha-1 Proteinase Inhibitors (human)
# Aralast NP
# Glassia
# Prolastin-C
# Zemaira
# Effective 01/01/2026

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|---|---|---|---|
| **Plan** | ☐ MassHealth UPPL<br>☒Commercial/Exchange | **Program Type** | ☒ Prior Authorization<br>☐ Quantity Limit<br>☐ Step Therapy |
| **Benefit** | ☒ Pharmacy Benefit<br>☐ Medical Benefit | | |
| **Specialty Limitations** | This medication has been designated specialty and must be filled at a contracted specialty pharmacy. | | |
| **Contact Information** | **Medical Benefit**<br>**Pharmacy Benefit** | Phone: 833-895-2611<br>Phone: 800-711-4555 | Fax: 888-656-6671<br>Fax: 844-403-1029 |
| **Exceptions** | N/A | | |

**Overview**
Aralast NP, Glassia, Prolastin-C and Zemaira are human plasma alpha-1 antitrypsin (AAT) products used to elevate AAT levels in the blood and lung interstitial tissue in the lungs, AAT deficiency causes chronic obstructive pulmonary disease (i.e., emphysema and bronchiectasis). These products are indicated for long-term augmentation and maintenance therapy in adults with severe hereditary deficiency of alpha$_1$-antitrypsin (AAT) with clinically evident emphysema.

**Coverage Guidelines**
Authorization may be granted for members new to the plan within the past 90 days who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance programs
**OR**
Authorization may be granted for members when all the following criteria have been met:

1. Member has a diagnosis of alpha 1-antitrypsin (AAT) deficiency
2. Member has clinically evident emphysema.
3. Member's pretreatment serum AAT level is less than 11 micromol/L (80 mg/dL by radial immunodiffusion or 50 mg/dL by nephelometry).
4. Member's pretreatment post-bronchodilation forced expiratory volume in 1 second (FEV1) is greater than or equal to 25% and less than or equal to 80% of the predicted value.
5. **For Aralast NP, Glassia and Zemaira:** the member has had documented intolerance, inadequate response or contraindication to Prolastin-C.

**Continuation of Therapy**
Requests for reauthorization will be approved when all of the following criteria are met:

1. Documentation of improvement of member's condition.

**Limitations**

1. Initial approvals and reauthorizations will be granted for 36 months

**References**


1. Aralast NP (alpha1-proteinase inhibitor, human) [prescribing information]. Cambridge, MA: Takeda Pharmaceutical Company Limited; ; May 2025
2. Glassia (alpha$_1$-proteinase inhibitor, human) [prescribing information]. Cambridge, MA: Takeda Pharmaceutical Company Limited; February 2025
3. Prolastin-C (alpha$_1$-proteinase inhibitor, human) [prescribing information]. Research Triangle Park, NC: Grifols Therapeutics, Inc; January 2022.
4. Zemaira (alpha$_1$-proteinase inhibitor, human) [prescribing information]. Kankakee, IL: CSL Behring; January 2024


**Review History**

11/18/2020-Updated: per 1/1/2021 strategy Prolastin C is the preferred agent. Changed all other products as non-preferred, changed approval duration from indefinite to 36 months: Nov P+T review.
10/08/2025 – Reviewed and updated at October P&T. Updated policy to reflect that it will no longer apply to the medical benefit. Updated language for members who are new to the plan. Effective 01/01/2026.