HIGHMARK HEALTH OPTIONS

Updated: 09/2026
DMMA Approved: 10/2026

Request for Prior Authorization for Zanvastro (zilganersen)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Zanvastro (zilganersen) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Zanvastro (zilganersen) Prior Authorization Criteria:

For all requests for Zanvastro (zilganersen), the following criteria must be met:

- Member has a diagnosis of Alexander disease confirmed by documentation including all of the following:
  - A clinical assessment of neurological and physical symptoms
  - MRI brain imaging
  - Genetic testing confirming the disease-causing/pathogenic GFAP gene variant consistent with Alexander disease
- Prescribed by, or in consultation with, a neurologist or other physician experienced in the diagnosis and management of Alexander disease.
- Documentation of the member's current clinical manifestations and gross motor skill level is provided including:
  - A baseline assessment appropriate to the member's age and functional ability or gross motor skill level (e.g. 10 meter walk test or Gross Motor Function Measure-88 (GMFM-88)) is documented to permit evaluation of disease course and treatment response.
- Zanvastro will be administered intrathecally by an appropriately trained healthcare professional in a setting capable of performing and monitoring lumbar puncture/intrathecal administration.
- Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines.
- Zanvastro will not be used concurrently with another disease-modifying therapy directed at the underlying GFAP-mediated mechanism of Alexander disease.
- **Initial Duration of Approval**: 6 months
- **Reauthorization Criteria:**
  - The member continues to have a diagnosis of Alexander disease
  - The provider documents that continued treatment remains clinically appropriate
  - Documented clinical assessments demonstrate clinical benefit or stabilization of disease, as appropriate for the member's age, gross motor function or baseline function, and manifestations
  - The member has not experienced toxicity or another safety issue that, in the treating provider's judgment, makes continued treatment inappropriate
  - The requested dose and remain consistent with FDA-approved prescribing information.
- **Reauthorization Duration of Approval**: 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

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ZANVASTRO (ZILGANERSEN)
PRIOR AUTHORIZATION FORM- PAGE 1 of 2

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Wholecare Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (800) 392-1147 Mon – Fri 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	Provider NPI:
Provider Specialty:	Office Contact:
State license #:	Office NPI:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

Is there documentation of the following to support a diagnosis of Alexander disease? ☐ Yes ☐ No

- A clinical assessment of neurological and physical symptoms
- MRI brain imaging
- Genetic testing confirming the disease-causing/pathogenic GFAP gene variant consistent with Alexander disease

Is there documentation of the member's current clinical manifestations and gross motor skill level including a baseline assessment appropriate to the member's age and functional ability or gross motor skill level (e.g. 10 meter walk test or Gross Motor Function Measure-88 (GMFM-88))? ☐ Yes ☐ No

Will the medication be administered intrathecally by an appropriately trained healthcare professional in a setting capable of performing and monitoring lumbar puncture/intrathecal administration? ☐ Yes ☐ No

Will Zanvastro be used concurrently with another disease-modifying therapy directed at the underlying GFAP-mediated mechanism of Alexander disease? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Is there documentation from the provider that continued treatment remains clinically appropriate? ☐ Yes ☐ No

Is there a documented clinical assessment demonstrating a clinical benefit or stabilization of disease, as appropriate for the member's age, gross motor function or baseline function, and manifestations? ☐ Yes ☐ No

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ZANVASTRO (ZILGANERSEN) PRIOR AUTHORIZATION FORM (CONTINUED)– PAGE 2 of 2		
Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Wholecare Pharmacy Services. **FAX:** (888) 245-2049 If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (800) 392-1147 Mon – Fri 8:30am to 5:00pm		
MEMBER INFORMATION		
Member Name:	DOB:	
Member ID:	Member weight:	Height:
Has the member experienced toxicity or another safety issue that, in the treating provider's judgment, making continued treatment inappropriate? ☐ Yes ☐ No		
Has the member experienced an improvement with treatment? ☐ Yes ☐ No		
SUPPORTING INFORMATION or CLINICAL RATIONALE		
Prescribing Provider Signature	Date	