

# Pharmacy Management Drug Policy

**SUBJECT: Monoclonal Antibodies for the Treatment of Hemophilia**

**POLICY NUMBER: PHARMACY-94**

**EFFECTIVE DATE: 10/01/2020**

**LAST REVIEW DATE: 01/08/2025**

*If the member's subscriber contract excludes coverage for a specific service or prescription drug, it is not covered under that contract. In such cases, medical or drug policy criteria are not applied. This drug policy applies to the following line/s of business:*

## Policy Application

<b>Category:</b>	<input checked="" type="checkbox"/> Commercial Group (e.g., EPO, HMO, POS, PPO)	<input checked="" type="checkbox"/> Medicare Advantage
	<input checked="" type="checkbox"/> On Exchange Qualified Health Plans (QHP)	<input type="checkbox"/> Medicare Part D
	<input checked="" type="checkbox"/> Off Exchange Direct Pay	<input checked="" type="checkbox"/> Essential Plan (EP)
	<input checked="" type="checkbox"/> Medicaid & Health and Recovery Plans (MMC/HARP)	<input checked="" type="checkbox"/> Child Health Plus (CHP)
	<input type="checkbox"/> Federal Employee Program (FEP)	<input type="checkbox"/> Ancillary Services
	<input checked="" type="checkbox"/> Dual Eligible Special Needs Plan (D-SNP)	

## DESCRIPTION:

Hemophilia is an inherited, lifelong bleeding disorder caused by deficiency of coagulation factors. The blood fails to clot which can result in bleeding into soft tissue, joints, and internal organs. It can also cause severe bleeding and death in trauma from intracranial bleeding. Hemophilia is an X-linked recessive disease that presents almost exclusively in male children of female carriers. The two most common types of hemophilia are Hemophilia A, which is a lack of Factor VIII and Hemophilia B, which is a lack of Factor IX.

There are varying severities of both hemophilia A and B depending upon the level of factor produced by the patient. Patients with severe hemophilia frequently experience bleeding even in the absence of trauma. Patients with moderate hemophilia experience less bleeding, and mild hemophilia patients usually experience bleeding only after obvious trauma. The severity classification system is based on the patient's factor activity level:

Disease Severity	Clotting Factor Level
Severe	< 1 IU/dl or < 1% of normal
Moderate	1-5 IU/dl or 1-5% of normal
Mild	5-40 IU/dl or 5 to < 40% of normal

The current treatment for both hemophilia A and B is to replace the deficient coagulation factor either through episodic (on demand) treatment which is replacement factor given at the time of bleeding or through continuous prophylaxis which is replacement factor given to prevent bleeding. Patients can develop antibodies to the factor, known as inhibitors, that will render the factor inactive (infused factor is seen as a foreign protein). Inhibitor development (both low and high titer inhibitors) can greatly interfere with the ability to treat bleeding and achieve adequate hemostasis. High titer inhibitors bind to exogenously administered replacement factor and prevent it from achieving hemostasis.

Hemlibra (emicizumab-kxwh) is a monoclonal antibody used for routine prophylaxis to prevent or decrease the frequency of bleeding episodes for patients with hemophilia A with or without factor VIII inhibitors. It is a bispecific factor IXa and factor-X directed antibody that works by bridging factor IXa and factor X to activate the natural coagulation cascade to restore the blood clotting process in hemophilia A, bypassing the need of FVIII.

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Hypvazi is a human monoclonal IgG1 antibody directed against the Kunitz domain 2 (K2) of tissue factor pathway inhibitor (TFPI) to neutralize TFPI activity and enhance coagulation. TFPI is the primary inhibitor of the extrinsic coagulation cascade and negatively regulates thrombin generation within the extrinsic pathway of coagulation by inactivating the protease functions of FXa/FVIIa/TF complex. TFPI binds to and inhibits the factor Xa active site via its second Kunitz inhibitor domain (K2).

#### **POLICY:**

##### **Hemlibra (emicizumab-kxwh) – Rx or Medical benefit**

1. Must be prescribed by a hematologist **AND**
2. Must be used for routine prophylaxis or to prevent or reduce frequency of bleeding episodes **AND**
3. Patient has a history of two or more episodes of spontaneous bleeding into joints or muscles **AND**
4. Must have a diagnosis of hemophilia A with inhibitors **OR**
5. Must have a diagnosis of hemophilia A without inhibitors
  - a. Patient must have severe hemophilia with a factor VIII <1% as confirmed by laboratory testing **AND**
  - b. Prescriber must attest that prophylactic use of bypassing agent will not occur while using Hemlibra **AND**
  - c. In addition to documentation of the patient's baseline annualized bleeding rate, the prescriber must provide documentation of continuation of spontaneous bleeds and/or inability to achieve appropriate trough level after a trial of prophylactic factor VIII replacement products
  - d. Use of Hemlibra due to convenience will not be considered medically necessary and will not be authorized
6. Approval will be for 2 years.
7. Recertification will require documentation that the patient has had a beneficial response (ex: reduction in bleeding events and/or severity, reduction in number of bleeding events requiring treatment and/or number of spontaneous bleeding events) to current therapy with Hemlibra
8. The recommended dosage is:
  - a. Initial dosage: 3mg/kg SC once weekly for 4 weeks
  - b. Maintenance dosage: 1.5 mg/kg once weekly **or** 3 mg/kg once every 2 weeks **or** 6 mg/kg once every 4 weeks

##### **Hypvazi (marstacimab-hncq) – Rx or Medical benefit**

1. Must be prescribed by a hematologist **AND**
2. The patient must be 12 years of age or older, weighing at least 35 kg **AND**
3. Must be used for routine prophylaxis to prevent or reduce the frequency of bleeding episodes **AND**
4. Patient has a history of two or more episodes of spontaneous bleeding into joints or muscles **AND**
5. The patient must have one of the following (a or b):
  - a. Hemophilia A and coagulation factor activity < 1% confirmed by laboratory testing
  - b. Hemophilia Band coagulation factor activity ≤ 2% confirmed by laboratory testing **AND**
6. Patient does NOT have inhibitors **AND**
7. The following must be provided:
  - a. Patient's baseline annualized bleeding rate **AND**
  - b. Documentation of continuation of spontaneous bleeds and/or inability to achieve appropriate trough level after a trial of prophylactic factor replacement products **AND**
8. For Hemophilia A ONLY, must have had a trial and failure of Hemlibra
9. Use of Hypvazi due to convenience will not be considered medically necessary and will not be authorized
10. Hypvazi will not be authorized in combination with prophylactic use of factor products. Factor products may continue to be used for breakthrough bleeds as necessary.
11. Hypvazi will not be authorized for use in combination with Hemlibra.

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12. Patient must not have received previous treatment with a gene therapy product for hemophilia
13. Approval will be provided for 2 years.
14. Recertification will require documentation that the patient has had a beneficial response (e.g., reduction in bleeding events and/or severity, reduction in number of bleeding events requiring treatment and/or number of spontaneous bleeding events) to current therapy with Hympavzi
15. The recommended dosage is:
  - a. Loading dose: 300 mg (two 150 mg injections) administered subcutaneously
  - b. Maintenance dose: 150 mg SC every week on the same day each week, beginning one week after the loading dose
    - i. Dose adjustments to 300 mg SC may be considered in patients weighing  $\geq 50$  kg when control of bleeding events is judged to be inadequate by the prescriber (documentation must be provided).
16. Quantity limit: 2 syringes/pens per 28 days

#### **APPROVAL TIME PERIODS:**

Line of Business	Initial approval	Recertification
Managed Medicaid (MMC) / Essential Plan (EP) / Child Health Plus (CHP) / Health and Recovery Program (HARP)	6 months	12 months
Commercial/Exchange/Medicare Part B	2 years	2 years

#### **POLICY GUIDELINES:**

1. Prior authorization is contract dependent.
2. Not all benefits allow coverage of healthcare professional administered drugs as part of their pharmacy benefit
3. This policy does not apply to Medicare Part D and D-SNP pharmacy benefits. The drugs in this policy may apply to all other lines of business including Medicare Advantage.
4. For members with Medicare Advantage, medications with a National Coverage Determination (NCD) and/or Local Coverage Determination (LCD) will be covered pursuant to the criteria outlined by the NCD and/or LCD. NCDs/LCDs for applicable medications can be found on the CMS website at <https://www.cms.gov/medicare-coverage-database/search.aspx>. Indications that have not been addressed by the applicable medication's LCD/NCD will be covered in accordance with criteria determined by the Health Plan (which may include review per the Health Plan's Off-Label Use of FDA Approved Drugs policy). Step therapy requirements may be imposed in addition to LCD/NCD requirements.
5. Clinical documentation must be submitted for each request (initial and recertification) unless otherwise specified (e.g., provider attestation required). Supporting documentation includes, but is not limited to, progress notes documenting previous treatments/treatment history, diagnostic testing, laboratory test results, genetic testing/biomarker results, imaging and other objective or subjective measures of benefit which support continued use of the requested product is medically necessary. Also, ongoing use of the requested product must continue to reflect the current policy's preferred formulary. Recertification reviews may result in the requirement to try more cost-effective treatment alternatives as they become available (i.e., generics, biosimilars, or other guideline supported treatment options). Requested dosing must continue to be consistent with FDA-approved or off-label/guideline-supported dosing recommendations.
  - Continued approval at time of recertification will require documentation that the drug is providing ongoing benefit to the patient in terms of improvement or stability in disease state or condition.
6. All non-FDA approved indications for Hemlibra will be evaluated using off label policy criteria.

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7. Dose and frequency should be in accordance with the FDA label or recognized compendia (for off-label uses). When services are performed in excess of established parameters, they may be subject to review for medical necessity.
8. Not all contracts cover all Medical Infusible drugs. Refer to specific contract/benefit plan language for exclusions of Injectable Medications.
9. All requests will be reviewed to ensure they are being used for an appropriate indication and may be subject to an off-label review in accordance with our Off-Label Use of FDA Approved Drugs Policy (Pharmacy-32).

#### **CODES:**

Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract.

Codes may not be covered under all circumstances. Please read the policy and guideline statements carefully.

Codes may not all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.

Code Key: Experimental/Investigational = (E/I). Not medically necessary/appropriate = (NMN).  
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#### **HCPCS:**

Description (Number): **Hemlibra** (J7170)

#### **UPDATES:**

<b>Date</b>	<b>Revision</b>
01/08/2025	Revised- Formerly named Hemlibra – policy name changed to Monoclonal Antibodies for Hemophilia
09/13/2024	Revised
06/24/2024	Revised
05/09/2024	P&T Committee Approval
04/19/2024	Revised
03/14/2023	Revised
12/15/2022	Revised
05/5/2022	P&T Committee Approval
05/6/2021	P&T Committee Approval
03/02/21	Revised
02/15/21	Revised
10/2020	Policy Effective
02/2020	Policy Created/P & T Approval

#### **REFERENCES:**

1. IPD Analytics. Hemophilia – Update on Treatment Management. Feb 2019. Accessed: Feb 1, 2020.
2. IPD Analytics. Hemlibra for use in Hemophilia. Nov 2018. Accessed: Feb 1, 2020.

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3. Recommendation on the Use and Management of Emicizumab-kxwh (Hemlibra®) for Hemophilia A with and without Inhibitors. National Hemophilia Foundation, Medical and Scientific Advisory Council. Accessed: Feb 1, 2020.
4. IPD Analytics. Hymravzi for use in Hemophilia. Oct 2024. Accessed: Dec 1, 2024