Clinical Policy: Factor VIII (Human, Recombinant)

Reference Number: CP.PHAR.215
Effective Date: 06.01.16
Last Review Date: 02.25
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

The following are factor VIII (FVIII) products requiring prior authorization: human – Hemofil M®, Koate-DVI®; recombinant – Advate®, Adynovate®, Afstyla®, Altuviiio™ , Eloctate®, Esperoct®, Helixate FS®, Jivi®, Kogenate FS®, Kovaltry®, Novoeight®, Nuwiq®, Obizur®, Recombinate®, Xyntha®, and Xyntha® Solofuse®.

FDA Approved Indication(s)

FVIII products are indicated for patients with hemophilia A for the following uses:

- Control and prevention of bleeding episodes:
  - Children and adults: Advate, Adynovate, Afstyla, Altuviiio, Eloctate, Esperoct, Helixate FS, Hemofil M, Jivi (in previously treated patients ≥ 7 years of age only), Koate-DVI, Kogenate FS, Kovaltry, Novoeight, Nuwiq, Recombinate, Xyntha
- Perioperative management:
  - Children and adults: Advate, Adynovate, Afstyla, Altuviiio, Eloctate, Esperoct, Helixate FS, Hemofil M, Jivi (in previously treated patients ≥ 7 years of age only), Koate-DVI, Kogenate FS, Kovaltry, Novoeight, Nuwiq, Recombinate, Xyntha
- Routine prophylaxis to prevent or reduce the frequency of bleeding episodes:
  - Adults only: Kogenate FS
  - Children and adults: Advate, Adynovate, Afstyla, Altuviiio, Eloctate, Esperoct, Helixate FS, Jivi (in previously treated patients ≥ 7 years of age only), Kovaltry, Novoeight, Nuwiq, Xyntha
- Routine prophylaxis to prevent or reduce the frequency of bleeding episodes and to reduce the risk of joint damage in children without pre-existing joint damage:
  - Children: Helixate FS, Kogenate FS
- On-demand treatment and control of bleeding episodes in acquired hemophilia A:
  - Adults: Obizur

Limitation(s) of use:

- FVIII products are not indicated for treatment of von Willebrand disease.
- Safety and efficacy of Obizur have not been established in patients with a baseline anti-porcine FVIII inhibitor titer of > 20 Bethesda units (BU).
- Jivi is not indicated for use in children < 7 years of age due to a greater risk for hypersensitivity reactions and/or loss of efficacy.
- Jivi is not indicated for use in previously untreated patients.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that FVIII products are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Hemophilia A (must meet all)**:**

1. Diagnosis of one of the following (a or b):
   a. Congenital hemophilia A (FVIII deficiency) (all products except Obizur);
   b. Acquired hemophilia A (Obizur only);
2. Prescribed by or in consultation with a hematologist;
3. Request is for one of the following uses (a, b, or c):
   a. Control and prevention of bleeding episodes;
   b. Perioperative management (all products except Obizur);
   c. Routine prophylaxis to prevent or reduce the frequency of bleeding episodes;
4. For routine prophylaxis requests: Request is for Advate, Adynovate, Afstyla, Altuviiio, Eloctate, Esperoct, Helixate FS, Jivi, Kogenate FS, Kovaltry, Novoeight, Nuwiq, or Xyntha;
5. For Jivi: Member meets both of the following (a and b):
   a. Age ≥ 7 years;
   b. Has previously been treated for hemophilia A;
6. Documentation of member's body weight (in kg);
7. Request meets one of the following (a or b):
   a. Dose does not exceed the FDA-approved maximum recommended dose for the relevant indication;
   b. If the requested agent will be used as part of an immune tolerance induction (ITI) regimen, dosing regimen is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

Approval duration:
Surgical/acute bleeding: 3 months
Prophylaxis and ITI:
Medicaid/HIM – 6 months (*12 months for prophylaxis for HIM Texas*)
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or

b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Hemophilia A (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets both (a and b):
   a. Documentation of member's body weight in kg (if requesting a higher dose than previously requested);
   b. One of the following (i or ii):
      i. New dose does not exceed the FDA-approved maximum recommended dose for the relevant indication;
      ii. If the requested agent is being used as part of an ITI regimen, dosing regimen is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

Approval duration:
Surgical/acute bleeding: 3 months
Prophylaxis and ITI:
Medicaid/HIM – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents;

B. Von Willebrand disease.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

BU: Bethesda units
FDA: Food and Drug Administration
FVIII: factor VIII
ITT: immune tolerance induction

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
  - Life-threatening hypersensitivity reactions, including anaphylaxis, to the product and its constituents*^
    **Including bovine, mouse, or hamster protein for Advate, Adynovate, Afstyla, Esperoct, Helixate FS, Hemofil M, Jivi, Kogenate FS, Kovaltry, Novoeight, Obizur, Recombinate, and Xyntha*
    ^Including polyethylene glycol (PEG) for Jivi
  - Obizur: congenital hemophilia A with inhibitors
- Boxed warning(s): none reported

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Antihemophilic factor – recombinant (Advate, Adynovate, Afstyla, Kovaltry, Novoeight, Nuwiq, Recombinate, ReFacto, Xyntha)	Control and prevention of bleeding episodes	Minor episodes: 10-20 IU/kg IV every 12-24 hours (Advate: 8-24 hours for age < 6 years) Moderate episodes: 15-30 IU/kg IV every 12-24 hours (Advate: 8-24 hours for age < 6 years)	50 IU/kg every 6 hours until the bleeding episode is resolved

Drug Name	Indication	Dosing Regimen	Maximum Dose
		Major episodes: 30-50 IU/kg IV every 8-24 hours (Advate: 6-12 hours for age < 6 years)	
Antihemophilic factor – recombinant, Fc-VWF-XTEN (Altuviiio)	Control and prevention of bleeding episodes	Minor and moderate episodes: 50 IU/kg IV as a single dose; for episodes occurring within 2-3 days after a prophylactic dose, a lower dose of 30 IU/kg may be used; additional doses of 30 or 50 IU/kg every 2-3 days may be considered Major episodes: 50 IU/kg IV as a single dose; additional doses of 30 or 50 IU/kg every 2-3 days may be considered	50 IU/kg/dose
Antihemophilic factor – recombinant, Fc fusion protein (Eloctate)	Control and prevention of bleeding episodes	Minor and moderate episodes: 20-30 IU/kg every 24-48 hours (12-24 hours for age < 6 years) Major episodes: 40-50 IU/kg every 12-24 hours (8 to 24 hours for age < 6 years)	50 IU/kg every 8 hours until the bleeding episode is resolved
Antihemophilic factor – recombinant (Helixate FS, Kogenate FS)	Control and prevention of bleeding episodes	Minor episodes: 10- 20 IU/kg IV; repeat dose if there is evidence of further bleeding Moderate episodes: 15-30 IU/kg IV every 12-24 hours Major episodes: initial 40-50 IU/kg IV, followed by 20-25 IU/kg every 8-24 hours	50 IU/kg single dose or 30 IU/kg/repeated dose

Drug Name	Indication	Dosing Regimen	Maximum Dose
		(Kogenate FS: every 8-12 hours)	
Antihemophilic factor – recombinant, glycopegylated (Esperoct)	Control and prevention of bleeding episodes	Minor to moderate episodes: 40-65 IU/kg IV; one dose should be sufficient for minor episodes; additional dose may be administered after 24 hours for moderate episodes. Major episodes: 50-65 IU/kg IV; additional doses may be administered approximately every 24 hours.	At least 12 years old: 40 IU/kg < 12 years old: 65 IU/kg
Antihemophilic factor – recombinant (Advate, Adynovate)	Perioperative management	Minor surgery: 30-50 IU/kg IV as a single dose within 1 hour of the operation and every 12-24 hours (Adynovate: 24 hours) thereafter as needed to control bleeding Major surgery: 40-60 IU/kg IV as a single dose preoperatively to achieve 100% activity and every 8- 24 hours thereafter to keep FVIII activity in desired range (Advate: every 6-24 hours for age < 6 years; Adynovate: every 6-24 hours if age < 12 years)	Minor surgery: 50 IU/kg/dose Major surgery: 60 IU/kg/dose
Antihemophilic factor – recombinant, Fc-VWF-XTEN (Altuviiio)	Perioperative management	Minor surgery: 50 IU/kg IV as a single dose; additional dose of 30 or 50 IU/kg after 2-3 days may be considered Major surgery: 50 IU/kg IV as a single dose;	50 IU/kg/dose

Drug Name	Indication	Dosing Regimen	Maximum Dose
		additional doses of 30 or 50 IU/kg every 2-3 days may be administered as clinically needed	
Antihemophilic factor – recombinant, Fc fusion protein (Eloctate)	Perioperative management	Minor surgery: 25-40 IU/kg every 24 hours (12-24 hours age < 6 years) Major surgery: pre-operative dose of 40-60 IU/kg followed by a repeat dose of 40-50 IU/kg after 8-24 hours (6-24 hours for age < 6 years) and then every 24 hours to maintain FVIII activity within the target range	Minor surgery: 40 IU/kg/dose Major surgery: 60 IU/kg/dose
Antihemophilic factor – recombinant, glycopegylated (Esperoct)	Perioperative management	Minor and major surgery: 50-65 IU/kg IV; additional doses can be administered after 24 hours if necessary for minor surgeries; additional doses can be administered approximately every 24 hours for the first week and then approximately every 48 hours until wound healing has occurred for major surgeries	≥ 12 years old: 50 IU/kg < 12 years old: 65 IU/kg
Antihemophilic factor – recombinant (Helixate FS, Kogenate FS)	Perioperative management	Minor surgery: 15- 30 IU/kg IV every 12-24 hours Major surgery: pre-operative dose of 50 IU/kg IV followed by a repeat dose every 6- 12 hours to maintain FVIII activity within the target range	Minor surgery: 30 IU/kg/dose Major surgery: 50 IU/kg/dose

Drug Name	Indication	Dosing Regimen	Maximum Dose
Antihemophilic factor – recombinant (Afstyla, Kovaltry, Novoeight, Nuwiq, Recombinate, Xyntha)	Perioperative management	Minor surgery: 15-30 IU/kg IV every 24 hours (Xyntha: every 12-24 hours) (Recombinate: 30- 40 IU/kg as a single infusion) Major surgery: 40-50 IU/kg IV every 8-24 hours (Xyntha: 30-50 IU/kg)	Minor surgery: 30 IU/kg/dose (Recombinate: 40 IU/kg/dose) Major surgery: 50 IU/kg every 8 hours
Antihemophilic factor – recombinant (Xyntha)	Routine prophylaxis	30 IU/kg IV 3 times weekly < 12 years of age: 25 IU/kg every other day	30 IU/kg/dose
Antihemophilic factor – recombinant (Advate)	Routine prophylaxis	20-40 IU/kg IV every other day (3 to 4 times weekly) OR Use every third day dosing regimen targeted to maintain FVIII trough levels ≥ 1%	40 IU/kg every other day
Antihemophilic factor – recombinant (Adynovate)	Routine prophylaxis	≥ 12 years of age: 40-50 IU/kg IV 2 times per week < 12 years of age: 55 IU/kg IV 2 times per week	70 IU/kg/dose
Antihemophilic factor – recombinant (Afstyla)	Routine prophylaxis	≥ 12 years of age: 20-50 IU/kg IV 2-3 times per week < 12 years of age: 30-50 IU/kg IV 2-3 times per week	50 IU/kg/dose
Antihemophilic factor – recombinant, Fc-VWF-XTEN (Altuviiio)	Routine prophylaxis	50 IU/kg IV once weekly	50 IU/kg/dose

Drug Name	Indication	Dosing Regimen	Maximum Dose
Antihemophilic factor – recombinant, Fc fusion protein (Eloctate)	Routine prophylaxis	50 IU/kg IV every 4 days For children < 6 years of age: 50 IU/kg IV twice weekly	65 IU/kg/dose
Antihemophilic factor – recombinant, glycopegylated (Esperoct)	Routine prophylaxis	≥ 12 years old: 50 IU/kg IV every 4 days < 12 years old: 65 IU/kg IV twice weekly	≥ 12 years old: 50 IU/kg < 12 years old: 65 IU/kg
Antihemophilic factor – recombinant (Helixate FS, Kogenate FS)	Routine prophylaxis	Adults: 25 IU/kg IV three times per week Children: 25 IU/kg every other day	25 IU/kg/dose
Antihemophilic factor – recombinant (Novoeight)	Routine prophylaxis	≥ 12 years of age: 20-50 IU/kg IV 3 times per week OR 20-40 IU/kg IV every other day < 12 years of age: 25-60 IU/kg IV 3 times per week OR 25-50 IU every other day	60 IU/kg/dose
Antihemophilic factor – recombinant (Nuwiq)	Routine prophylaxis	≥ 12 years of age: 30-40 IU/kg IV every other day < 12 years of age: 30-50 IU/kg IV every other day or 3 times/week	50 IU/kg/dose
Antihemophilic factor – recombinant (Kovaltry)	Routine prophylaxis	> 12 years of age: 20-40 IU/kg IV 2-3 times per week ≤ 12 years of age: 25-50 IU/kg twice or three times weekly or every other day according to individual requirements	50 IU/kg every other day
Antihemophilic factor – recombinant,	Treatment of bleeding	200 IU/kg every 4-12 hours	200 IU every 4 hours

Drug Name	Indication	Dosing Regimen	Maximum Dose
porcine sequence (Obizur)	episodes in acquired hemophilia A		
Antihemophilic factor – human (Hemofil M)	Control and prevention of bleeding episodes	Minor episodes: 10- 20 IU/kg IV every 12-24 hours Moderate episodes: 15-30 IU/kg IV every 12-24 hours Major episodes: 30- 50 IU/kg IV every 8-24 hours	100 IU/kg every 8 hours
Antihemophilic factor – human (Koate-DVI)	Control and prevention of bleeding episodes	Minor episodes: 10 IU/kg IV as a single dose; repeat only if there is evidence of further bleeding Moderate episodes: 15-25 IU/kg IV as a single dose followed by 10-15 IU/kg every 8-12 hours if needed Major episodes: 40- 50 IU/kg IV as a single dose followed by 20-25 IU/kg IV every 8-12 hours	25 IU/kg every 8 hours until the bleeding episode is resolved
Antihemophilic factor – human (Hemofil M)	Perioperative management	Minor surgery: 30- 40 IU/kg as a single infusion Major surgery: 40-50 IU/kg every 8-24 hours	Minor surgery: 80 IU/kg/dose Major surgery: 100 IU/kg every 8 hours
Antihemophilic factor – human (Koate-DVI)	Perioperative management	Major surgery: 50 IU/kg pre-operative dose followed by 50 IU/kg every 6-12 hours as needed	Major surgery: 50 IU/kg every 6 hours

Drug Name	Indication	Dosing Regimen	Maximum Dose
		Minor surgery: less intensive schedules may be adequate	
Antihemophilic factor – recombinant, PEGylated-aucl (Jivi)	Control and prevention of bleeding episodes	Minor episodes: 10-20 IU/kg every 24-48 hours Moderate episodes: 15-30 IU/kg every 24-48 hours Major episodes: 30-50 IU/kg every 8-24 hours	50 IU/kg every 8 hours
	Perioperative management	Minor surgery: 15-30 IU/kg every 24 hours Major surgery: 40-50 IU/kg every 12-24 hours	Minor surgery: 30 IU/kg/dose Major surgery: 50 IU/kg/dose
	Routine prophylaxis	≥ 12 years of age: 30-40 IU/kg twice weekly; may be adjusted to 45-60 IU/kg every 5 days with further individual adjustment to less or more frequent dosing 7 to < 12 years of age: 60 IU/kg twice weekly; adjust based on the patient's clinical response and/or recovery	60 IU/kg/dose; frequency varies based on bleeding episodes

VI. Product Availability

Drug Name	Availability
Antihemophilic factor – recombinant (Advate)	Vial: 250, 500, 1,000, 1,500, 2,000, 3,000, 4,000 IU
Antihemophilic factor – recombinant (Adynovate)	Vial: 250, 500, 750, 1,000, 1,500, 2,000, 3,000 IU
Antihemophilic factor – recombinant (Afstyla)	Vial: 250, 500, 1,000, 1,500, 2,000, 2,500, 3,000 IU

Drug Name	Availability
Antihemophilic factor – recombinant (Altuviiio)	Vial: 250, 500, 750, 1,000, 2,000, 3,000, 4,000 IU
Antihemophilic factor – recombinant (Eloctate)	Vial: 250, 500, 750, 1,000, 1,500, 2,000, 3,000 4,000, 5,000, 6,000 IU
Antihemophilic factor – recombinant, glycopegylated-exei (Esperoct)	Vial: 500, 1,000, 1,500, 2,000, 3,000, 4,000, 5,000 IU
Antihemophilic factor – recombinant (Helixate FS, Kogenate FS, Kovaltry)	Vial: 250, 500, 1,000, 2,000, 3,000 IU
Antihemophilic factor – recombinant (Novoeight)	Vial: 250, 500, 1,000, 1,500, 2,000, 3,000 IU
Antihemophilic factor – recombinant (Nuwiq)	Vial: 250, 500, 1,000, 1,500, 2,000, 2,500, 3,000, 4,000 IU
Antihemophilic factor – recombinant (Recombinate)	Vial: 220-400, 401-800, 801-1240, 1241-1800, 1801-2400 IU
Antihemophilic factor – recombinant (ReFacto, Xyntha)	Vial: 250, 500, 1,000, 2,000 IU
Antihemophilic factor – recombinant (Xyntha Solofuse)	Prefilled syringe: 250, 500, 1,000, 2,000, 3,000 IU
Antihemophilic factor – recombinant (Obizur)	Vial: 500 IU
Antihemophilic factor – human (Hemofil M)	Vial: 250, 500, 1,000, 1,700 IU
Antihemophilic factor – human (Koate-DVI)	Vial: 250, 500, 1,000 IU
Antihemophilic factor – recombinant, PEGylated-aucl (Jivi)	Vial: 500, 1,000, 2,000, 3,000, 4,000 IU

VII. References

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Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J7204	Injection, factor VIII, antihemophilic factor (recombinant), (Esperoct), glycopegylated-exei, per IU
J7205	Injection, factor VIII fc fusion protein (recombinant), per iu
J7207	Injection, factor VIII (antihemophilic factor, recombinant) pegylated, 1 IU
J7208	Injection, factor VIII, (antihemophilic factor, recombinant), pegylated-aucl, (Jivi), 1 IU
J7209	Injection, factor VIII (antihemophilic factor, recombinant) (Nuwiq), 1 IU
J7210	Injection, factor VIII, (antihemophilic factor, recombinant), (Afstyla), 1 IU
J7214	Injection, factor VIII/von willebrand factor complex, recombinant (Altuviiio), per factor vii IU
J7211	Injection, factor VIII, (antihemophilic factor, recombinant), (Kovaltry), 1 IU
J7182	Injection, factor VIII, (antihemophilic factor, recombinant), (NovoEight), per IU
J7185	Injection, factor VIII (antihemophilic factor, recombinant) (Xyntha), per IU
J7188	Injection, factor VIII (antihemophilic factor, recombinant) (Obizur), per IU
J7190	Factor VIII (antihemophilic factor, human) per IU
J7191	Factor VIII (antihemophilic factor, porcine) per IU
J7192	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2021 annual review: added requirement for documentation of member's body weight for calculation of appropriate dosage; removed ReFacto from the policy as it is no longer available; removed references to valoctocogene roxaparvovec as it did not receive FDA approval and likely will not face FDA review again until at least late 2022; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	12.01.20	02.21
Added a requirement for high utilizers of FVIII products for routine prophylaxis to use Hemlibra.	09.20.21	11.21
1Q 2022 annual review: removed the redirection to Hemlibra for high factor utilizers until data analysis re: potential cost savings is complete; updated HCPCS codes; references reviewed and updated.	11.27.21	02.22
Clarified requirement for coverage of FVIII for routine prophylaxis: the requirement for FVIII activity level or documentation of bleed history only applies to requests for new starts to routine prophylactic therapy.	03.03.22	05.22
Template changes applied to other diagnoses/indications and continued therapy section.	10.03.22	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2023 annual review: Removed "life-threatening" from "life-threatening or serious bleed" criterion as definition of what is serious vs life-threatening may not be mutually exclusive and there exists potential for misinterpretation; references reviewed and updated.	11.08.22	02.23
RT4: Altuviiio added to the policy; updated HCPCS codes; references reviewed and updated.	03.09.23	
Extended initial and continued authorization durations for hemophilia prophylaxis from 6 months to 12 months for HIM Texas.	08.28.23	
Added HCPCS code [J7214]	10.26.23	
1Q 2024 annual review: no significant changes; updated sites of serious bleeds per WFH guideline in Appendix D; added Altuviiio coding implications; references reviewed and updated.	09.27.23	02.24
Added pathway for off-label use as ITI if regimen is supported by practice guidelines or peer-reviewed literature; for continued therapy clarified that member's current weight is only needed if a higher dose is being requested. Per March SDC, removed criteria for routine prophylaxis regarding severity of hemophilia, prior use of factor VIII, and Appendix D; removed desmopressin redirection.	04.10.24	05.24
1Q 2025 annual review: for Medicaid and HIM lines of business, continued approval duration revised from 6 months to 12 months for prophylaxis and ITI; for Commercial line of business, all prophylaxis approval durations revised to "6 months or to the member's renewal date, whichever is longer;" references reviewed and updated.	11.01.24	02.25
RT4: added new 4,000 IU vial strength for Jivi.	02.04.25	
RT4: updated age from ≥ 12 years of age to ≥ 7 years of age for Jivi per age extension.	06.09.25	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a

component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.