Pharmacy Management Drug Policy

SUBJECT: Monoclonal Antibodies for the Treatment of Hemophilia
POLICY NUMBER: PHARMACY-94
EFFECTIVE DATE: 10/01/2020
LAST REVIEW DATE: 11/19/2025

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

Category:	☒ Commercial Group (e.g., EPO, HMO, POS, PPO)	☒ Medicare Advantage
	☒ On Exchange Qualified Health Plans (QHP)	☐ Medicare Part D
	☒ Off Exchange Direct Pay	☒ Essential Plan (EP)
	☒ Medicaid & Health and Recovery Plans (MMC/HARP)	☒ Child Health Plus (CHP)
	☐ Federal Employee Program (FEP)	☐ Ancillary Services
	☒ 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.

Hympazi 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).

Alhemo is a monoclonal antibody antagonist of endogenous TFPI. Through the inhibition of TFPI, Alhemo acts to enhance FXa production during the initiation phase of coagulation which leads to improved thrombin generation and clot formation with the goal of achieving hemostasis in patients with hemophilia A or B with inhibitors. The effect of Alhemo is not influenced by the presence of inhibitory antibodies to FVIII or FIX. There is no structural relationship or sequence homology between Alhemo and FVIII or FIX and, as such, treatment with Alhemo does not induce or enhance the development of direct inhibitors to FVIII or FIX.

POLICY:

Alhemo ((concizumab-mtci) – 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 25 kg **AND** 3. Must have a diagnosis of congenital FVIII deficiency (hemophilia A) or congenital FIX deficiency (hemophilia B) **AND** 4. Must have documentation of inhibitors (e.g. history of inhibitor titer ≥5 Bethesda units per mL) **AND** 5. Must be used for routine prophylaxis to prevent or reduce the frequency of bleeding episodes **AND** 6. Patient has a history of two or more episodes of spontaneous bleeding into joints or muscles **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 bypassing agents **AND** 8. For Hemophilia A ONLY, must have had a trial and failure of Hemlibra 9. Use of Alhemo due to convenience will not be considered medically necessary and will not be authorized 10. Alhemo will not be authorized in combination with prophylactic use of bypassing agents. Bypassing agents may continue to be used for breakthrough bleeds as necessary. 11. Alhemo will not be authorized for use in combination with Hemlibra or Hympavzi. 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 Alhemo 15. Upon each review the requested pen strength and quantity will be reviewed in accordance with FDA-approved weight-based dosing. Approval will be limited to the minimum number of pens needed to obtain the appropriate dose and pen strength that provides the least amount of waste. 16. The recommended dosage is: a. Day 1: Loading dose of 1 mg/kg b. Maintenance dose: Day 2: Once-daily dose of 0.2 mg/kg until individualization of maintenance dose i. 4 weeks after initiation of treatment: For dose optimization measure concizumab-mtci plasma concentration by Concizumab Enzyme-Linked Immunosorbent Assay (ELISA) prior to administration of next scheduled dose.).

c. Once the concizumab-mtci concentration result is available, individualize the maintenance dose of Alhemo no later than 8 weeks after initiation of treatment, based on the following concizumab-mtci-plasma concentrations:
   i. Less than 200 ng/mL: adjust to a once-daily dose of 0.25 mg/kg
   ii. 200 to 4000 ng/mL: continue once-daily dose of 0.2 mg/kg
   iii. Greater than 4000 ng/mL: adjust to a once-daily dose of 0.15 mg/kg

17. Quantity limit: 1 pen per 28 days

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. Hemlibra will not be authorized in combination with prophylactic use of bypassing agents. Bypassing agents may continue to be used for breakthrough bleeds as necessary.
6. 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
7. trough level after a trial of prophylactic factor replacement products
8. Use of Hemlibra due to convenience will not be considered medically necessary and will not be authorized
9. Approval will be for 2 years.
10. 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
11. 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

Hympavzi (marstacimab-hncg) – 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 B and 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 Hympavzi due to convenience will not be considered medically necessary and will not be authorized
10. Hympavzi 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. Hympavzi will not be authorized for use in combination with Hemlibra.
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 ≥ 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

Qfitlia (fitusiran) – Rx or Medical benefit

1. Must be prescribed by a hematologist **AND**
2. The patient must be 12 years of age or older **AND**
3. Must have a diagnosis of congenital FVIII deficiency (hemophilia A) or congenital FIX deficiency (hemophilia B) **AND**
4. Must be used for routine prophylaxis to prevent or reduce the frequency of bleeding episodes **AND**
5. Patient has a history of two or more episodes of spontaneous bleeding into joints or muscles **AND**
6. 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**
7. For Hemophilia A ONLY, must have had a trial and failure of Hemlibra
8. Use of Qfitlia due to convenience will not be considered medically necessary and will not be authorized
9. Qfitlia will not be authorized in combination with prophylactic use of factor products. Factor products may continue to be used for breakthrough bleeds as necessary.
10. Qfitlia will not be authorized for use in combination with Hemlibra, Hympavzi or Alhemo.
11. Patient must not have received previous treatment with a gene therapy product for hemophilia
12. Documentation of or prescriber attestation of AT activity >60% prior to treatment initiation and documentation of planned follow-up and monitoring with AT activity to adjust dose is required
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 Alhemo
15. The recommended dosage is:
    a. Starting dose: 50 mg once every 2 months.
    b. After treatment initiation, patients may continue their prior clotting factor concentrates (CFC) or bypassing agent (BPA) prophylaxis for the first 7 days of treatment; these should be discontinued no later than 7 days after the initial dose.
    c. Monitor AT activity using an FDA-cleared test at Weeks 4 (Month 1), 12 (Month 3), 20 (Month 5), and 24 (Month 6) following the starting dose and after any dose modification.
        i. If any AT activity is <15%, a dose reduction is required. The lower dose should be initiated 3 months after the prior dose. AT measurements should be restarted after a dose reduction.
        ii. If AT activity is >35% after 6 months, or if the patient has not achieved satisfactory bleed

control, dose escalation should be considered. AT measurements should be restarted after a dose escalation.

d. Maintain AT activity between 15% and 35% by adjusting the dose and/or frequency of administration. Once the patient's target dose is identified based on AT activity 15%–35%, measure AT activity annually. Additional AT measurements can be considered if bleeding control is not adequate.

16. Quantity limit: 0.5 mL/56 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.
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).
10. All utilization management requirements outlined in this policy are compliant with applicable New York State insurance laws and regulations. Policies will be reviewed and updated as necessary to ensure ongoing compliance with all state and federally mandated coverage requirements.
11. Manufacturers may either discontinue participation in, or may not participate in, the Medicaid Drug Rebate Program (MDRP). Under New York State Medicaid requirements, physician-administered drugs must be produced by manufacturers that participate in the MDRP. Products made by manufacturers that do not participate in the MDRP will not be covered under Medicaid Managed Care/HARP lines of business. Drug coverage will not be available for any product from a non-participating manufacturer. For a complete list of New/Reinstated & Terminated Labelers please visit: https://www.medicaid.gov/medicaid/prescriptiondrugs/medicaid-drug-rebate-program/newreinstated-terminated-labeler-information/index.html

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).

HCPCS:

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

UPDATES:

Date	Revision
11/19/2025	Revised
06/25/2025	Revised
05/08/2025	Reviewed / P&T Committee Approval
04/01/2025	Revised
03/06/2025	Revised
02/25/2025	Revised
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.
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. Hympavzi for use in Hemophilia. Oct 2024. Accessed: Dec 1, 2024
5. IPD Analytics. Alhemo for use in Hemophilia. Jan 2025. Accessed: Feb 10, 2024