Pharmacy Management Drug Policy

SUBJECT: Monoclonal Antibodies for the Treatment of Hemophilia
POLICY NUMBER: PHARMACY-94
EFFECTIVE DATE: 10/01/2020
LAST REVIEW DATE: 06/17/2026

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 specific coagulation factors. This deficiency results in impaired blood clot formation which, in affected individuals, can lead to spontaneous or trauma-related bleeding into soft tissue, joints, muscles, and internal organs. Severe bleeding events (e.g., intracranial hemorrhage) may be life-threatening or fatal.

Hemophilia is an X-linked recessive disorder that presents almost exclusively in male children of female carriers. The two most common types of hemophilia are Hemophilia A, which is characterized by a deficiency in coagulation factor VIII (FVIII) and Hemophilia B, which is characterized by a deficiency in coagulation factor IX (FIX).

Disease Severity

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

Clinically Significant Bleeding

The International Society on Thrombosis and Haemostasis (ISTH) defines clinically significant bleeding as bleeding events requiring hemostatic intervention, including:

- Spontaneous joint bleeds (hemarthrosis), which are a primary driver of progressive arthropathy
- Muscle hematomas, particularly in anatomically critical locations such as the iliopsoas
- Mucosal bleeding that requires medical intervention
- Post-traumatic bleeding that does not resolve spontaneously

- Life-threatening bleeding events, including intracranial hemorrhage, retroperitoneal bleeding, chest or abdominal bleeding, or neck and throat bleeding that require immediate intervention to achieve near-normal clotting activity

Treatment Overview
The cornerstone of management 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 factor products, known as inhibitors. Inhibitors render 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.

Episodic versus Prophylactic Therapy
Episodic (on-demand) treatment has been shown to be clinically inferior to prophylactic therapy with respect to bleeding prevention, joint preservation, and long-term outcomes. Clinical trials and observational studies consistently demonstrate higher bleeding rates, progressive joint damage, and worse functional outcomes in patients managed with episodic therapy compared to those receiving routine prophylaxis.

Episodic therapy fails to prevent subclinical and micro-bleeding events that drive irreversible joint damage and does not adequately mitigate disease progression. Therefore, prophylactic therapy is the established standard of care for individuals with moderate to severe hemophilia or a high-risk bleeding phenotype.

Episodic treatment is not considered an appropriate long-term management strategy or qualifying pathway for coverage under this policy. Routine use of episodic therapy alone suggests a disease course or bleeding phenotype that is inconsistent with the severity and risk profile required for coverage of the treatments addressed in this policy.

Coverage Intent and Scope
This policy applies to monoclonal antibody therapies for the management of hemophilia A and hemophilia B in individuals with moderate to severe disease or a high-risk bleeding phenotype for whom routine prophylaxis is clinically indicated.

Coverage is intended for patients who demonstrate a disease course associated with recurrent clinically significant bleeding, elevated risk of spontaneous hemorrhage, or progressive joint damage. Eligibility for coverage is not based on diagnosis alone and is determined by satisfaction of the clinical criteria described below.

POLICY:

	Hemlibra (emicizumab-kxwh)	Hympavzi (marstacimab-hncq)	Alhemo (concizumab-mtci)	Qfitlia (fitusiran)
Congenital FVIII deficiency (hemophilia A)				
With	X	X	X	X
Without	X	X	X	X
Congenital FIX deficiency (hemophilia B)				
With		X	X	X
Without		X	X	X
FDA Approved Age Requirement				
All Indications	Any age	≥ 6 years of age	≥ 12 years of age	≥ 12 years of age

1. The prescribed medication must be used for the indication(s) consistent with the population outlined in the table above
2. Must be prescribed by, or in consultation with, a hematologist
3. Must be used for routine prophylaxis to prevent or reduce the frequency of bleeding episodes
4. Inhibitor Status Requirements
    a. For patients ***WITH*** inhibitors, there must be documentation of inhibitors (e.g., history of inhibitor titer ≥5 Bethesda units per mL)
        i. For Hemophilia A, Bethesda assay must have been completed within 8 weeks of the request
        ii. For Hemophilia B, a Bethesda assay completed within 6 months of the request is acceptable unless recent immune-tolerance induction or clinical change that suggest assessment is warranted
    b. For patients ***WITHOUT*** inhibitors:
        i. Patients must have severe hemophilia A (factor VIII <1%) or hemophilia B (IX ≤ 2%) as evidenced by documentation of baseline (untreated) factor activity level **AND**
        ii. Must have documentation of a recent (within 6 months of the request) inhibitor test confirming absence of factor VIII (for hemophilia A) or factor IX (for hemophilia B) inhibitors
5. Bleed History Requirements
    a. Documentation of the patient's baseline annualized bleed rate (ABR)
        i. Only bleeds requiring medical intervention or treatment should be counted in ABR calculations **AND**
    b. The patient must have a history of two or more episodes of spontaneous bleeding episodes into joints or muscles consistent with moderate to severe hemophilia **AND**
    c. There must be documentation of inadequate bleed control despite ≥ 80% adherence (based on refill history or infusion logs) of prophylactic therapy as evidenced by:
        i. Two or more clinically significant spontaneous bleeding events within the past 12 months requiring medical intervention or treatment (e.g., factor infusion, bypassing agent, or clinical evaluation) while adherent to prophylactic factor replacement or bypassing agents **OR**
        ii. Inability to achieve or maintain appropriate trough factor activity level ≥ 3% as evidenced by at least two pre-dose levels < 3% obtained ≥ 4 weeks apart within a 6-month period, despite appropriate dosing
6. Patients with **Hemophilia A** must have had a trial and failure of Hemlibra prior to consideration of coverage for another hemophilia monoclonal antibody therapy.
    a. An adequate trial of Hemlibra is defined as the completion of the 4-week loading dose in addition to at least 24 weeks of maintenance therapy at an approved dose with confirmed

adherence, unless discontinued earlier due to serious side effects or documentation of neutralizing antibodies

b. Failure of Hemlibra is defined as any of the following:
   i. An increase in treated spontaneous or joint bleeds compared to pre-treatment baseline (e.g., increase in ABR, return to pre-treatment bleeding frequency) **OR**
   ii. Bleeding requiring additional factor or bypassing agent therapy (beyond what is typical for minor trauma or surgery) **OR**
   iii. Failure to prevent target joint bleeds or new joint damage

7. Hemlibra, Hympavzi, Alhemo, and Qfitlia will not be authorized in combination with another monoclonal antibody used for Hemophilia or, when used for prophylaxis, with factor products or bypassing agents **except** for intermittent use to manage breakthrough bleeds
8. Coverage Exclusions
   a. Patient must not have received previous treatment with a gene therapy product for hemophilia, due to insufficient evidence on safety and/or efficacy of subsequent use with non-factor agents
   b. Use in acquired hemophilia is excluded from coverage, as there is no clinical evidence or guideline support for the safety and/or efficacy of these agents in this population
9. Transition to non-factor therapies may be considered medically necessary when there is documented clinical ineffectiveness associated with factor replacement therapy as described in the criteria above.
   a. Use of these therapies to reduce treatment burden (for convenience), in the absence of such clinical factors, does not meet medical necessity criteria and will not be authorized.
10. Recertification
   a. Recertification requires documentation that the patient has had a beneficial response to therapy (e.g., reduction in frequency and/or severity in spontaneous bleeding events, decreased need for intermittent factor or bypassing therapy, etc.)
11. See Prescribing Information for approved dosing

Quantity Limit

- Hemlibra
  - The most efficient vial and strength combination should be used to minimize drug waste, consistent with the FDA-approved dosing regimen and the patient's prescribed dose.
- Hympavzi: 4 syringes/pens per 28 days
- Alhemo: 1 pen per 28 days
  - 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.
- Qfitlia: 0.5 mL per 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. Utilization Management is contract dependent. Refer to specific contract/benefit language for exclusions.
   a. Coverage criteria may be dependent on the contract renewal date.
   b. Coverage of drugs listed in this policy are contract dependent.
   c. Not all contracts/benefits allow coverage of healthcare professional administered drugs as part of their pharmacy benefit
   d. Not all contracts/benefits cover all medical infusible drugs.
2. 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. If a drug referenced in this policy is non-formulary, please refer to the Non-Formulary Medication Exception Review Policy (Pharmacy-69)
3. 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.
4. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS permits a Medicare Advantage Organization (MAO) to establish its own coverage determinations in accordance with 42 CFR § 422.101(b)(6).
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 and treatment history, diagnostic testing, laboratory test results, genetic testing or biomarker results, imaging, and other objective or subjective measures of clinical benefit.
   a. For recertification, continued approval requires documentation demonstrating that the requested product is providing ongoing benefit to the patient, evidenced by improvement or stability in the disease state or condition, and that continued use remains medically necessary. Ongoing use of the requested product must continue to align with the current policy's preferred formulary. Recertification reviews may result in a requirement to trial more cost-effective treatment alternatives as they become available (e.g., generics, biosimilars, or other guideline-supported treatment options). Requested dosing must remain consistent with FDA-approved or off-label/guideline-supported dosing recommendations.
6. 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).

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. 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).
9. 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.
10. 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
11. For commercial contracts, medical necessity determinations align with the Certificate of Coverage issued by the Health Plan, which states that covered services must be clinically appropriate and not primarily for the convenience of the member, the member's family, or the provider.
12. The requested site of care may impact approval timeframe and subject to review.

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:

Brand Name	Generic Name	HCPCS
Hemlibra	emicizumab-kxwh	J7170
Hympavzi	marstacimab-hncq	J7172
Alhemo	concizumab-mtci	J7173
Qfitlia	fitusiran	J7174

UPDATES:

Date	Revision
06/17/2026	Revised
06/01/2026	Revised
05/14/2026	Reviewed / P&T Committee Approval
04/17/2026	Revised

11/19/2025	Revised
06/25/2025	Revised
05/08/2025	Reviewed / P&T Committee Approval
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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

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