CareSource

PHARMACY POLICY STATEMENT **Georgia Medicaid**	
DRUG NAME	Antihemophilic agents: Advate, Adynovate, Afstyla, Alphanate and Alphanate/VWF Complex/Human, AlphaNine SD, Alprolix, Autoplex T, Bebulin and Bebulin VH, BeneFIX, Bioclate, Coagadex, Corifact, Eloctate, Factor VIII SD (Human), Feiba, Feiba NF, and Feiba VH Immuno, Fibryga, Helixate and Helixate FS, Hemlibra, Hemofil M, Humate-P and Humate-P Human, Hyate:C, Idelvion, Ixinity, Jivi, Kcentra, Koate, Koate-DVI, and Koate-HP, Kogenate, Kogenate FS, and Kogenate FS Bio-Set, Konyne 80, Kovaltry, Melate, Monarc-M, Monoclate-P, Mononine, Novoeight, NovoSeven and NovoSeven RT, Nuwiq, Obizur, Profilnine and Profilnine SD, Proplex T Factor IX Complex, Rebinyn, Recombinate, Refacto, RiaSTAP, Rixubis, Tretten, Vonvendi, Wilate, Xyntha and Xyntha Solofuse
BILLING CODE	J7199
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient/Home
COVERAGE REQUIREMENTS	Prior Authorization Required QUANTITY LIMIT— see package insert for each individual drug
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

All antihemophilic agents will only be considered for coverage under the medical benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

HEMOPHILIA

For **initial** authorization:

1. Member has diagnosis of Hemophilia A or Hemophilia B; AND
2. Member's weight in kilograms, measured within the last 180 days, is documented on medication prior authorization request.
3. **Dosage allowed:** Per package insert of individual drug.

Notes: Documented diagnosis must be confirmed by portions of the individual's medical record which need to be supplied with prior authorization request. These medical records may include, but are not limited to test reports, chart notes from provider's office, or hospital admission notes. Refer to the product package insert for dosing, administration and safety guidelines.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member's updated measurement of weight in kilograms is documented on medication prior authorization request; AND
2. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource considers antihemophilic agents not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
12/15/2016	Policy issued.
06/12/2018	Policy placed in a new format. Initial authorization length increased to 6 months.
10/05/2018	New drug Jivi added to the list of antihemophilic agents.

References:

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