

PHARMACY POLICY STATEMENT

Michigan Medicaid

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| DRUG NAME | Hemophilia and Other Clotting Disorders |
| BENEFIT TYPE | Pharmacy or medical: Alhemo, Hemlibra, Hympavzi, Qfitlia Medical only: all others |
| STATUS | Prior Authorization Required |

Hemophilia is the most common severe hereditary hemorrhagic disorder. Hemophilia A and B result from factor VIII and factor IX protein deficiency or dysfunction, respectively, and can result in prolonged and excessive bleeding after minor trauma. Spontaneous bleeding is also possible. Hemophilia A is more common than hemophilia B, representing 80–85% of the total hemophilia population.

Hemophilia and Other Clotting Disorders will be considered for coverage when the following criteria are met:

Hemophilia A (Factor VIII Deficiency)

For initial authorization:

1. Member has diagnosis of Hemophilia A (congenital Factor VIII deficiency); AND
2. For Jivi, member must be 7 years of age or older; AND
3. Medication is being prescribed by or in consultation with a hematologist; AND
4. Medication will be used for applicable situations listed in Table A or for Immune Tolerance Induction (ITI); AND
5. If request is for ITI, member must have severe hemophilia (factor level < 1%) with inhibitors (FVIII titre > 0.6 BU), and meet one of the following:
 - a. Inhibitor titre < 10 BU/mL or titre fails to fall below 10 BU/mL within a year;
 - b. Member is having severe or life-threatening bleeding;
 - c. Member is having frequent bleeding and is being considered for bypassing agent prophylaxis; AND
6. If request is for Altuvio, member has had a trial and failure of a standard half-life FVIII product OR extended half-life FVIII product; AND
7. Member's recent weight (kg), history of bleeds, number of as needed doses on hand, and inhibitor status have been provided for review.
8. **Dosage allowed:** Per package insert of individual drug. For ITI, dosages may range from 50 IU/kg three times weekly to 200 IU/kg daily depending on titer inhibitor levels.

If all the above requirements are met, the medication will be approved for 30 days for perioperative management or 6 months for all other cases.

Note: Approval will be for requested dosage, but no more than +/- 5-10% of prescribed assays. For patients on prophylaxis: the number of as needed doses the patient has on hand will be taken into

consideration for treatment of acute bleeding episodes. A maximum of 5 as needed doses will be permitted at a time.

For reauthorization:

1. Member's recent weight (kg), history of bleeds, number of as needed doses on hand, and inhibitor status have been provided for review; AND
2. Member has experienced positive clinical response from the use of factor; AND
3. If request is for a dosage increase, provider must submit a clinical rationale supported by chart notes; AND
4. For ITI, chart notes have been provided to show both of the following:
 - a. Member continues to need ITI (e.g., inhibitor is detectable (> 0.6 BU), FVIII recovery $< 66\%$ of expected, FVIII half-life is < 7 hours); AND
 - b. Member has shown at least 20% decline in the inhibitor titre level since the previous approval.

If all the above requirements are met, the medication will be approved for an additional 6 months.

Hemophilia B (Factor IX Deficiency)

For initial authorization:

1. Member has diagnosis of Hemophilia B (congenital Factor IX deficiency); AND
2. For Ixinity, member must be 12 years of age or older; AND
3. For AlphaNine, member must be 17 years of age or older; AND
4. Medication is being prescribed by or in consultation with a hematologist; AND
5. Medication will be used for applicable situations listed in Table A or for Immune Tolerance Induction (ITI); AND
6. If request is for ITI, member must have inhibitors (FIX titre ≥ 0.3 BU) and prescriber must attest that benefit outweighs the risk of starting therapy; AND
7. Member's recent weight (kg), history of bleeds, number of as needed doses on hand, and inhibitor status have been provided for review.

8. **Dosage allowed:** Per package insert of individual drug.

If all the above requirements are met, the medication will be approved for 30 days for perioperative management or 6 months for all other cases.

Note: Approval will be for requested dosage, but no more than +/- 5-10% of prescribed assays. For patients on prophylaxis: the number of as needed doses the patient has on hand will be taken into consideration for treatment of acute bleeding episodes. A maximum of 5 as needed doses will be permitted at a time.

For reauthorization:

1. Member's recent weight (kg), history of bleeds, number of as needed doses on hand, and inhibitor status have been provided for review; AND
2. Member has experienced positive clinical response from the use of factor; AND
3. If request is for a dosage increase, provider must submit a clinical rationale supported by chart notes.

If all the above requirements are met, the medication will be approved for an additional 6 months.

FEIBA (anti-inhibitor coagulant complex)

For initial authorization:

1. Member has a diagnosis of Hemophilia A or B with confirmed inhibitors (FVIII titre > 0.6 BU for hemophilia A or FIX titre \geq 0.3 BU for hemophilia B); AND
2. Medication is being prescribed by or in consultation with a hematologist; AND
3. Medication will be used in one of the following situations:
 - a. On-demand treatment of acute bleeding episodes;
 - b. Perioperative management of bleeding;
 - c. Routine prophylaxis to prevent or reduce the frequency of bleeding episodes; AND
4. Member's recent weight (kg), history of bleeds, and inhibitor status have been provided for review; AND
5. If member is using Hemlibra, must have a clinical reason why a recombinant activated factor VII (rFVIIa) such as NovoSevenRT or Sevenfact cannot be used.
6. **Dosage allowed:** Per package insert.

If member meets all the requirements listed above, the medication will be approved for 30 days for perioperative management or 6 months for all other cases.

Note: Approval will be for requested dosage, but no more than +/- 5-10% of prescribed assays.

For reauthorization:

1. Member's recent weight (kg), history of bleeds, and inhibitor status have been provided for review; AND
2. Member has experienced positive clinical response from the use of factor; AND
3. If request is for a dosage increase, provider must submit a clinical rationale supported by chart notes.

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

Novoseven RT (Recombinant Factor VIIa)

For initial authorization:

1. Medication is being prescribed by or in consultation with a hematologist; AND
2. Medication is being used for the treatment of bleeding episodes OR perioperative management for one of the following diagnoses:
 - a. Hemophilia A or B with confirmed inhibitors (FVIII titre > 0.6 BU for hemophilia A or FIX titre ≥ 0.3 BU for hemophilia B);
 - b. Acquired hemophilia;
 - c. Congenital Factor VII (FVII) deficiency;
 - d. Glanzmann's Thrombasthenia and platelet transfusion was either ineffective or contraindicated; AND
3. Member's recent weight (kg), history of bleeds, and inhibitor status (if applicable) have been provided for review.
4. **Dosage allowed:** Per package insert.

If member meets all the requirements listed above, the medication will be approved for 30 days for perioperative management or 6 months for all other cases.

Note: Approval will be for requested dosage, but no more than +/- 5-10% of prescribed assays.

For reauthorization:

1. Member's recent weight (kg), history of bleeds, and inhibitor status (if applicable) have been provided for review; AND
2. Member has experienced positive clinical response from the use of factor; AND
3. If request is for a dosage increase, provider must submit a clinical rationale supported by chart notes.

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

Sevenfact (Recombinant Factor VIIa)

For **initial** authorization:

1. Member is 12 years of age or older; AND
2. Member has a diagnosis of Hemophilia A or B with confirmed inhibitors (FVIII titre > 0.6 BU for hemophilia A or FIX titre \geq 0.3 BU for hemophilia B); AND
3. Medication is being prescribed by or in consultation with a hematologist; AND
4. Medication will be used as on-demand treatment of acute bleeding episodes; AND
5. Member's recent weight (kg), history of bleeds, and inhibitor status have been provided for review.
6. **Dosage allowed:** Per package insert.

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

Note: Approval will be for requested dosage, but no more than +/- 5-10% of prescribed assays.

For **reauthorization:**

1. Member's recent weight (kg), history of bleeds, and inhibitor status have been provided for review; AND
2. Member has experienced positive clinical response from the use of factor; AND
3. If request is for a dosage increase, provider must submit a clinical rationale supported by chart notes.

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

Hemlibra (emicizumab-kxwh)

For **initial** authorization:

1. Member has diagnosis of Hemophilia A, with congenital factor VIII deficiency confirmed by blood coagulation testing; AND
2. Medication is being prescribed by or in consultation with a hematologist; AND
3. Member's recent weight (kg), history of bleeds, and inhibitor status have been provided for review; AND
4. For member with factor VIII inhibitors, member must meet the following:
 - a. Chart notes with documented positive test for inhibitors (titer > 0.6 BU/mL [Bethesda unit per milliliter]); OR
5. For member without factor VIII inhibitors, member must have severe hemophilia A (Factor VIII level $<1\%$); AND
6. Bypassing agents (e.g., Feiba, NovoSeven RT, Sevenfact) are discontinued the day before starting Hemlibra (if applicable); AND
7. Prophylactic use of factor replacements are discontinued after loading dose period is finished. ***Note:*** Factor VIII may be used as on-demand therapy for breakthrough bleeding
8. **Dosage allowed:** 3 mg/kg subQ once weekly for the first 4 weeks, followed by a maintenance dose of 1.5 mg/kg once every week, OR 3mg/kg once every 2 weeks, OR 6 mg/kg every 4 weeks.



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

Note: Approval will be for the lowest number of vials to achieve requested dosage.

For reauthorization:

1. Member's recent weight in kilograms is documented on medication prior authorization request; AND
2. Chart notes have been provided showing that the member experienced a reduction in bleeding episodes compared to baseline.

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

Hympavzi (marstacimab-hncq)

For initial authorization:

1. Member is at least 12 years of age; AND
2. Medication is being prescribed by or in consultation with a hematologist; AND
3. Member has diagnosis of one of the following:
 - a. Severe hemophilia A (indicated by 1% or less of normal circulating factor VIII) or
 - b. Moderate to severe hemophilia B (indicated by 2% or less of normal circulating factor IX); AND
4. Member does NOT have factor inhibitors; AND
5. Member has tried and failed a compliant regimen of factor prophylaxis or Hemlibra; AND
6. Prophylactic therapy will be discontinued before initiating Hympavzi; AND
7. Member will NOT use Hympavzi for breakthrough bleeds.
8. **Dosage allowed/Quantity limit:** 300 mg subcutaneous loading dose, followed by 150 mg subcutaneous once weekly dose. Consider dose adjustment to 300 mg once weekly in patients weighing more than 50 kg when control of bleeding events is judged to be inadequate. Quantity limit: 4 syringes/pens (150 mg/mL) per 28 days after loading dose

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

For reauthorization:

1. Chart notes must show member experienced a reduction in bleeding episodes compared to baseline.

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

Alhemo (concizumab-mtci)

For initial authorization:

1. Member is at least 12 years of age; AND
2. Medication is being prescribed by or in consultation with a hematologist; AND

3. Member has a documented diagnosis of congenital hemophilia A or B; AND
4. For members with inhibitors, member meets **BOTH** of the following:
 - a. Documented history of factor inhibitor, equal to or above 0.6 Bethesda Units (BU);
 - b. Prescribed, or in need of, treatment with bypassing agents in the last 24 weeks; AND
5. For members WITHOUT inhibitors, member has severe hemophilia A (FVIII below 1%) or B (FIX equal to or below 2%); AND
6. Member's weight and bleeding history are documented; AND
7. Member will discontinue any other prophylactic therapy being used for hemophilia.
8. **Dosage allowed/Quantity limit:** Administer subcutaneously once daily as follows:
Day 1: Loading dose of 1 mg/kg
Day 2: 0.2 mg/kg once daily until individualization of maintenance dose
4 weeks after initiation: Measure Alhemo plasma concentration
No later than 8 weeks after initiation: Individualize maintenance dose based on Alhemo plasma concentration:
<200 ng/mL: 0.25 mg/kg
200 to 4,000 ng/mL: 0.2 mg/kg
>4,000 ng/mL: 0.15 mg/kg

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

For reauthorization:

1. Chart notes must document a positive clinical response to treatment, such as fewer bleeding episodes compared to no prophylactic treatment; AND
2. Alhemo plasma concentration is being maintained above 200 ng/mL.

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

Qfitlia (fitusiran)

For initial authorization:

1. Member is at least 12 years of age; AND
2. Medication is being prescribed by or in consultation with a hematologist; AND
3. Member has diagnosis of severe congenital hemophilia A or B; AND
4. Member has documentation of antithrombin (AT) activity > 60% prior to treatment initiation; AND
5. Provider attests member will discontinue prophylactic therapy being used for hemophilia; AND
6. Chart notes include documentation of bleeding history.
7. **Dosage allowed/Quantity limit:** initial dose of 50 mg subcutaneously once every 2 months. Maintain AT activity between 15-35% by adjusting the dose and/or frequency of administration per package insert. Quantity limit: 1 pen or vial per 28 days.

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

For reauthorization:

1. Chart notes must show member experienced a reduction in bleeding episodes compared to baseline; AND
2. Documentation that member's target AT activity is between 15 and 35%

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

Von Willebrand Disease (VWD)

For initial authorization:

1. Member has a diagnosis of Von Willebrand Disease (VWD); AND
2. For Vonvendi, member must be 18 years of age or older; AND
3. Medication is being prescribed by or in consultation with a hematologist; AND
4. Medication will be used for applicable situations listed in Table A; AND
5. Member has severe vWD (except Alphanate) OR Member has mild or moderate vWD and the use of desmopressin is known or suspected to be ineffective or contraindicated; AND
6. Member's recent weight (kg) and history of bleeds have been provided for review.
7. **Dosage allowed:** Per package insert of individual drug.

If member meets all the requirements listed above, the medication will be approved for 30 days for perioperative management, or 6 months for all other cases.

Note: Approval will be for requested dosage, but no more than +/- 5-10% of prescribed assays.

For reauthorization:

1. Member's recent weight (kg) and history of bleeds have been provided for review; AND
2. Member has experienced positive clinical response from the use of factor; AND
3. If request is for a dosage increase, provider must submit a clinical rationale supported by chart notes.

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

Miscellaneous Factors - Obizur, Coagadex, Corifact, Tretten, Fibryga, RiaSTAP

For initial authorization:

1. For Obizur, member must be 18 years of age or older with a baseline anti-porcine factor VIII inhibitor titer less than 20 BU; AND
2. Member has an FDA approved indication for use as listed in Table A; AND
3. Medication is being prescribed by or in consultation with a hematologist; AND

4. Member's recent weight (kg), history of bleeds, and fibrinogen level (if available, Fibryga and RiaSTAP only) have been provided for review.
5. **Dosage allowed:** Per package insert.

If member meets all the requirements listed above, the medication will be approved for 30 days for perioperative management or 6 months for all other cases.

Note: Approval will be for requested dosage, but no more than +/- 5-10% of prescribed assays.

For reauthorization:

1. Member's recent weight (kg) and history of bleeds have been provided for review; AND
2. Member has experienced positive clinical response from the use of factor; AND
3. If request is for a dosage increase, provider must submit a clinical rationale supported by chart notes.

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

Anti-Clotting Products - ATryn, Ceprotin

For initial authorization:

1. Member has an FDA approved indication for use as listed in Table A; AND
2. Medication is being prescribed by or in consultation with a hematologist; AND
3. Member's recent weight (kg) and chart notes supporting diagnosis have been provided for review.
4. **Dosage allowed:** Per package insert.

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

For reauthorization:

1. Member's recent weight (kg) and documentation of positive clinical response have been submitted for review; AND
2. If request is for a dosage increase, provider must submit a clinical rationale supported by chart notes.

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

Table A

| Drug Class | Drug Name | Indications |
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| Recombinant Factor VIII (Hemophilia A) | Advate | <ul style="list-style-type: none"> • On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes |

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| | Afstyla | <ul style="list-style-type: none"> • On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes |
| | Kovaltry | <ul style="list-style-type: none"> • On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes |
| | Novoeight | <ul style="list-style-type: none"> • On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes |
| | Nuwiq Recombinate | <ul style="list-style-type: none"> • On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes |
| | Xyntha | <ul style="list-style-type: none"> • On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes |
| Extended Half-Life Recombinant Factor VIII (Hemophilia A) | Adynovate | <ul style="list-style-type: none"> • On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes |
| | Alteviiio | <ul style="list-style-type: none"> • On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes |
| | Eloctate | <ul style="list-style-type: none"> • On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes |
| | Esperoct | <ul style="list-style-type: none"> • On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes |
| | Jivi | <ul style="list-style-type: none"> • On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes |
| Non-Factor (Hemophilia A) | Hemlibra | <ul style="list-style-type: none"> • Routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adults and pediatric patients with hemophilia A with or without factor VIII inhibitors |
| Recombinant Factor IX (Hemophilia B) | Benefix | <p>Hemophilia B (congenital factor IX deficiency) for:</p> <ul style="list-style-type: none"> • On-demand treatment and control of bleeding episodes • Perioperative management of bleeding • Routine prophylaxis to reduce the frequency of bleeding episodes |
| | Ixinity | <ul style="list-style-type: none"> • On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes |
| | Rixubis | <ul style="list-style-type: none"> • On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes |
| Extended Half-Life Recombinant Factor IX (Hemophilia B) | Alprolix | <ul style="list-style-type: none"> • On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes |

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| | Idelvion | <ul style="list-style-type: none"> On-demand treatment and control of bleeding episodes Perioperative management Routine prophylaxis to reduce the frequency of bleeding episodes |
| | Rebinyn | <ul style="list-style-type: none"> On-demand treatment and control of bleeding episodes Perioperative management Prevention and control of bleeding episodes |
| Plasma-Derived Factor IX (Hemophilia B) | AlphaNine SD | <ul style="list-style-type: none"> Prevention and control of bleeding episodes |
| Factor IX Complex (Hemophilia B) | Profilnine SD | <ul style="list-style-type: none"> Prevention and control of bleeding episodes |
| von Willebrand Factor/Coagulation Factor VIII Complex (Human) | Alphanate | <ul style="list-style-type: none"> Control and prevention of bleeding in patients with hemophilia A Surgical and/or invasive procedures in adult and pediatric patients with von Willebrand Disease in whom desmopressin (DDAVP) is either ineffective or contraindicated. Not indicated for patients with severe VWD (Type 3) undergoing major surgery |
| | Humate-P | <p>Hemophilia A</p> <ul style="list-style-type: none"> Treatment and prevention of bleeding in adults <p>Von Willebrand disease</p> <ul style="list-style-type: none"> Treatment of spontaneous and trauma-induced bleeding episodes Perioperative management |
| | Wilate | <p>Children and adults with von Willebrand disease for:</p> <ul style="list-style-type: none"> On-demand treatment and control of bleeding episodes Perioperative management Routine prophylaxis to reduce the frequency of bleeding episodes <p>Adolescents and adults with hemophilia A for:</p> <ul style="list-style-type: none"> On-demand treatment and control of bleeding episodes Routine prophylaxis to reduce the frequency of bleeding episodes |
| vonWillebrand Recombinant Factor | Vonvendi | <p>Adults with von Willebrand disease for:</p> <ul style="list-style-type: none"> On-demand treatment and control of bleeding episodes Perioperative management Routine prophylaxis to reduce the frequency of bleeding episodes in patients with severe Type 3 von Willebrand disease receiving on-demand therapy. |
| Bypassing Agent | Feiba | <p>Hemophilia A and B with inhibitors for:</p> <ul style="list-style-type: none"> On-demand treatment and control of bleeding episodes Perioperative management Routine prophylaxis to reduce the frequency of bleeding episodes |
| | NovoSeven RT | <ul style="list-style-type: none"> Treatment of bleeding episodes and peri-operative management in adults and children with hemophilia A or B with inhibitors Congenital Factor VII (FVII) deficiency Glanzmann's thrombasthenia with refractoriness to platelet transfusions, with or without antibodies to platelets Treatment of bleeding episodes and peri-operative management in adults with acquired hemophilia |
| | SevenFact | <ul style="list-style-type: none"> On-demand treatment of bleeding episodes in adults and adolescents with hemophilia A or B with inhibitors |
| Miscellaneous Factor | Obizur | <ul style="list-style-type: none"> On-demand treatment of bleeding episodes in adults with acquired hemophilia A |

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| | Coagadex | Hereditary Factor X deficiency for: <ul style="list-style-type: none"> • Routine prophylaxis to reduce the frequency of bleeding episodes • On-demand treatment and control of bleeding episodes • Perioperative management of bleeding in patients with mild, moderate and severe hereditary Factor X deficiency |
| | Corifact | <ul style="list-style-type: none"> • Routine prophylactic treatment and peri-operative management of surgical bleeding in patients with congenital Factor XIII deficiency |
| | Tretten | <ul style="list-style-type: none"> • Prophylaxis of bleeding in patients with congenital Factor XIII A-Subunit deficiency |
| | Fibryga | <ul style="list-style-type: none"> • Treatment of acute bleeding episodes in adults and children with congenital fibrinogen deficiency, including afibrinogenemia and hypofibrinogenemia • Fibrinogen supplementation in bleeding patients with acquired fibrinogen deficiency |
| | RiaSTAP | <ul style="list-style-type: none"> • Treatment of acute bleeding episodes in adults and children with congenital fibrinogen deficiency, including afibrinogenemia and hypofibrinogenemia |
| | Antithrombin | <ul style="list-style-type: none"> • <u>Prevention</u> of peri-operative and peri-partum thromboembolic events in patients with hereditary antithrombin deficiency |
| | Protein C Concentrate | <ul style="list-style-type: none"> • Treatment and prevention of venous thrombosis and purpura fulminans in patients with severe congenital Protein C deficiency |

HAP CareSource considers Hemophilia and Other Clotting Disorders not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

| DATE | ACTION/DESCRIPTION |
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| 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. |
| 08/06/2019 | New drug Esperoct added to the list of antihemophilic agents. |
| 10/19/2019 | Policy updated to include Hemlibra criteria. |
| 08/01/2020 | Hemlibra criteria updated to include hematologist. Requirement changed for members without Factor VIII inhibitors to align better with current practice and clinical trials. |
| 04/02/2021 | Title updated to encompass all bleeding disorder products. Table A created for all products, indications, and J codes. Added separate criteria set for hemophilia A, hemophilia B, Feiba, NovoSevenRT, Sevenfact, Von Willebrand Disease, miscellaneous factors, and anti-clotting products (previously only had one set of criteria for hemophilia factor replacement). Updated Hemlibra's weight requirement, reauth criteria, and dosage allowed section. Added |

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| | approval instruction note for the factors and Hemlibra. Updated initial approval duration for all agents. |
| 09/13/2022 | Annual Review. Transferred to new template. Updated references. Removed discontinued medications from policy (Helixate, Kogenate). Updated Table A indications (VonVendi). Added baseline titer requirements for Obizur. |
| 04/10/2023 | Added Altuviiio and as needed acute bleed dosing guidance for prophylaxis to hemophilia A. Changed name from bleeding disorder agents to hemophilia and other clotting disorders. Added trial of Jivi (for extended half-life products) and Advate (for standard half-life products) for hemophilia A. Added a note that Hemlibra is preferred for long-term prophylaxis for hemophilia A. Removed trial of factor products, clinical reason factors cannot be used or poor venous access for patients who are not using factor products with Hemlibra. |
| 01/05/2024 | Added severe indication for perioperative management of bleeding for Coagadex; added indication of routine prophylaxis to reduce the frequency of bleeding episodes for Wilate; updated references |
| 05/15/2024 | Removed age limit for Ixinity. |
| 07/02/2024 | Removed Jivi and Advate trials and added a trial of an extended half-life or standard half-life FVIII product for Altuviiio. |
| 10/15/2024 | Added acquired fibrinogen deficiency indication for Fibryga. Added criteria for Hympavzi. |
| 01/03/2025 | Updated references. Added criteria section for Alhemo. |
| 04/14/2025 | Added Qfitlia criteria section. Updated Hympavzi, Hemlibra and Alhemo to pharmacy or medical benefit; removed Hemofil and Recombinate from policy per discontinuation. |
| 06/19/2025 | Updated references; reduced age limit from 12 to 7 years of age per PI for Jivi |
| 08/15/2025 | Added criteria for patients who are not on inhibitors per label update, specified bypassing agent criteria is only for patients on inhibitors |

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