Clinical Policy: Factor VIII (Human, Recombinant)

Reference Number: CP.PHAR.215
Effective Date: 05/16
Last Review Date: 05/17

Coding Implications
Revision Log

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

Description
The intent of the criteria is to ensure that patients follow selection elements established by Centene® clinical policy for factor VIII (Human – Hemofil M®, Koate®, Koate-DVI®, Monoclate-P®; Recombinant - Advate®, Adynovate®, Afstyla®, Eloctate®, Helixate FS®, Kogenate FS®, Kogenate FS with Vial Adapter®, Kogenate FS with Bio-Set®, Kovaltry®, NovoEight®, Nuwiq®, Obizur®, Recombinate®, ReFacto®, Xyntha®, Xyntha® Solofuse™).

Policy/Criteria
It is the policy of health plans affiliated with Centene Corporation® that Advate, Adynovate, Afstyla, Eloctate, Helixate FS, Hemofil M, Koate, Koate-DVI, Kogenate FS, Kogenate FS with Vial Adapter, Kogenate FS with Bio-Set, Kovaltry, Monoclate-P, NovoEight, Nuwiq, Obizur, Recombinate, ReFacto, Xyntha, Xyntha Solofuse are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Congenital Hemophilia A (must meet all):
1. Prescribed by or in consultation with a hematologist;
2. Diagnosis of congenital hemophilia A (factor VIII deficiency);
3. Request is for one of the following uses:
   a. Control and prevention of bleeding episodes:
      i. Obizur is not approved for congenital hemophilia A;
   b. Perioperative management:
      i. Obizur is not approved for congenital hemophilia A;
   c. Routine prophylaxis to prevent or reduce the frequency of bleeding episodes:
      i. Obizur is not approved for congenital hemophilia A;
4. Member does not have von Willebrand disease (VWD);
5. Intravenous (IV) desmopressin is inadequate, inappropriate or contraindicated, or an appropriate formulation of IV desmopressin is not available;
6. If Xyntha is prescribed, contraindication to or has failed Advate (e.g., inhibitor production or hypersensitivity), or Advate is not available.

Approval duration:
3 months (bleeding episodes/surgery)
6 months (routine prophylaxis)

B. Acquired Hemophilia A (must meet all):
1. Prescribed by or in consultation with a hematologist;
2. Diagnosis of acquired hemophilia A;

3. Request is for one of the following uses:
   a. Control and prevention of bleeding episodes:
   b. Perioperative management:
   c. Routine prophylaxis to prevent or reduce the frequency of bleeding episodes;
4. Member does not have VWD.

Approval duration: 3 months

C. Other diagnoses/indications: Refer to CP.PHAR.57 - Global Biopharm Policy.

II. Continued Approval

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

1. Currently, receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Member is responding positively to therapy.

Approval duration:
3 months (bleeding episodes/surgery)
6 months (routine prophylaxis)

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

1. Currently, receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Member is responding positively to therapy.

Approval duration: 3 months

C. Other diagnoses/indications (1 or 2)**:**

1. Currently, receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or

2. Refer to CP.PHAR.57 - Global Biopharm Policy**.**

Background

Description/Mechanism of Action:
Factor VIII replacement, necessary for clot formation and maintenance of hemostasis, activates factor X in conjunction with activated factor IX. Activated factor X converts prothrombin to thrombin, which converts fibrinogen to fibrin, and with factor XIII forms a stable clot.

- Congenital hemophilia A: Inherited factor VIII deficiency.
- Acquired hemophilia A: Normal factor VIII genes with development of autoantibodies (inhibitors) against factor VIII. The autoantibodies neutralize circulating factor VIII and create a functional deficiency.

Formulations (from human plasma):
Solution Reconstituted, IV:

- Hemofil M: 250; 500; 1000; 1700 (units)
- Koate: 250; 500; 1000 (units) *[replacing Koate-DVI]*
- Koate-DVI: 250; 500; 1000 (units) *[phasing out]*
- Monoclate-P: 1000; 1500 (units)

Formulations (recombinant human unless otherwise noted):
Solution Reconstituted, IV:

- Advate: 250; 500; 1000; 1500; 2000; 3000; 4000 (units)
- Adynovate (pegylated/longer-lasting): 250; 500; 750; 1000; 1500; 2000 (units)
- Afstyla: 250; 500; 1000; 2000; 3000 (units)
- Eloctate (Fc fusion/longer-lasting): 250; 500; 750; 1000; 1500; 2000; 3000; 4000; 5000; 6000 (units)
- Helixate FS: 250; 500; 1000; 2000; 3000 (units)
- Kogenate FS: 250, 500, 1000, 2000, 3000 (units)
- Kogenate FS with Bio-Set: 250, 500, 1000, 2000, 3000 (units)
- Kogenate FS with Vial Adapter: 2000; 3000 (units)
- Kovaltry: 250; 500; 1000; 2000; 3000 (units)
- NovoEight: 250; 500; 1000; 1500; 2000; 3000 (units)
- Nuwiq: 250; 500; 1000; 2000 (units)
- Obizur *(recombinant porcine):* 500 (units)
- Recombinate: 220-400; 401-800; 801-1240; 1241-1800; 1801-2400 (units)
- ReFacto: 250; 500; 1000; 2000 (units)
- Xyntha: 250, 500; 100; 2000 (units)
- Xyntha Solofuse: 250; 500; 100; 2000; 3000 (units)

FDA-Approved Indications
Congenital hemophilia A (factor VIII deficiency) indications and approved products:

- Control and prevention of bleeding episodes:
  - Children and adults: Advate, Adynovate, Afstyla, Eloctate, Helixate FS, Hemofil M, Koate, Koate-DVI, Kogenate FS, Kovaltry, Monoclate-P, NovoEight, Nuwiq, Recombinate, ReFacto, Xyntha, Xyntha Solofuse
- Perioperative management:
  - Children and adults: Advate, Adynovate, Afstyla, Eloctate, Helixate FS, Hemofil M, Koate, Koate-DVI, Kogenate FS, Kovaltry, Monoclate-P, NovoEight, Nuwiq, Recombinate, ReFacto, Xyntha, Xyntha Solofuse
- Routine prophylaxis to prevent or reduce the frequency of bleeding episodes:
  - Children and adults: Advate, Adynovate, Afstyla, Eloctate, Helixate FS, Kogenate FS, Kovaltry, NovoEight, Nuwiq, Recombinate, ReFacto (short-term)
- 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

  Limitations of use: The products listed above are not indicated for treatment of VWD.

Acquired hemophilia A indications and approved products:

- Treatment of bleeding episodes:
  - Adults: Obizur

    Limitations of use: Safety and efficacy of Obizur has not been established in patients with baseline antiporcine factor VIII inhibitor titer greater than 20 BU. Obizur is not indicated for the treatment of congenital hemophilia A or VWD.

Appendices

Appendix A: Abbreviation Key

IV: intravenous
VWD: von Willebrand disease

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
C9137	Injection, factor VIII (antihemophilic factor, recombinant) PEGylated, 1 IU
C9138	Injection, factor VIII (antihemophilic factor, recombinant) (Nuwiq), 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), per IU
J7190	Factor VIII (antihemophilic factor, human) per IU
J7192	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified

Reviews, Revisions, and Approvals	Date	Approval Date
Policy split from CP.PHAR.12.Blood Factors and converted to new template. Added Kovaltry; removed requests for documentation; added 12 and older per PI indications if Adynovate. Removed preferencing for Helixate before Kogenate and Refacto. Under initial criteria, removed requirement for "severe hemophilia" and "history of 2 or more joint bleeds for prophylaxis indication." Non-prophylactic approval duration changed to 3 months initially with one 3-month re-auth. Removed denial based on inhibitor titer of ≥5 BU/mL. Reviewed by specialist.	04/16	05/16
Product updates: Afstyla added (new drug); Adynovate updated to include perioperative management and use in children; Koate added - Koate-DVI	04/17	05/17

Reviews, Revisions, and Approvals	Date	Approval Date
being phased out; Kogenate is available via three different PIs as Kogenate FS, Kogenate FS with Vial Adapter and Kogenate FS with Bio-Set; Obizur added (new drug for acquired hemophilia); ReFacto – removed "short term" use from criteria; Xyntha Solofuse added (same indications as Xyntha). Required trial of desmopressin is edited to avoid necessity of testing for coagulation factors.Safety information removed. Removed age >18 age restriction for Obizur per specialist recommendation. Wording for uses of all blood factor products made consistent across all policies. Per specialist review, for congenital hemophilia A, opened indications for routine prophylaxis up to all drugs listed in the policy, except Obizur. Approval periods across all blood factor policies made consistent. Efficacy statement added to renewal criteria. Hemophilias are specified as "congenital" versus "acquired" across blood factor policies where indicated. Reviewed by specialist- hematologist/internal medicine.		

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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.

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.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.