# Clinical Policy: Factor VIII/von Willebrand Factor Complex (Human - Alphanate, Humate-P, Wilate)

Reference Number: CP.PHAR.216
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/von Willebrand factor complex (Alphanate®, Humate-P®, Wilate®).

## Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation® that Alphanate, Humate-P, and Wilate are **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria**

**A. Congenital Hemophilia A – Alphanate/Humate-P** (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 control and prevention of bleeding episodes;
4. Intravenous (IV) desmopressin is inadequate, inappropriate or contraindicated, or an appropriate formulation of IV desmopressin is unavailable;
5. If Humate-P is prescribed, age ≥ 18 years.

**Approval duration: 3 months**

**B. Von Willebrand Disease** (must meet all)**:**

1. Prescribed by or in consultation with a hematologist;
2. Humate P or Wilate (a and b):
   a. Diagnosis of (i or ii):
      i. Von Willebrand disease (VWD) Type 1 or 2 and IV desmopressin is inadequate, inappropriate or contraindicated, or an appropriate formulation of IV desmopressin is unavailable;
      ii. VWD Type 3;
   b. Request is for (i or ii):
      i. Control and prevention of bleeding episodes;
      ii. Perioperative management;
3. Alphanate (a and b):
   a. Diagnosis of (i or ii):
      i. VWD Type 1 or 2 and desmopressin is inadequate, inappropriate or contraindicated, or an appropriate formulation of desmopressin is unavailable;
      ii. VWD Type 3;
   b. Request is for perioperative management.

**Approval duration: 3 months**

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

**II. Continued Approval**

**A. All indications listed in Section I** (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**

**B. Other diagnoses/indications** (must meet 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 (FVIII) and von Willebrand factor (VWF), obtained from pooled human plasma, are used to replace endogenous FVIII and VWF in patients with hemophilia or VWD. FVIII in conjunction with activated factor IX, activates factor X which converts prothrombin to thrombin and fibrinogen to fibrin. VWF promotes platelet aggregation and adhesion to damaged vascular endothelium and acts as a stabilizing carrier protein for FVIII. Circulating levels of functional VWF are measured as ristocetin cofactor activity (VWF:RCo).

*Formulations (from human plasma):*

Solution, Reconstituted, IV:

- Alphanate
  - FVIII 250 units and VWF:RCo > 400 units per 1000 units FVIII
  - FVIII 500 units and VWF:RCo > 400 units per 1000 units FVIII
  - FVIII 1000 units and VWF:RCo > 400 units per 1000 units FVIII
  - FVIII 1500 units and VWF:RCo > 400 units per 1000 units FVIII
  - FVIII 2000 units and VWF:RCo > 400 units per 1000 units FVIII
- Humate-P
  - FVIII 250 units and VWF:RCo 600 units
  - FVIII 500 units and VWF:RCo 1200 units
  - FVIII 1000 units and VWF:RCo 2400 units
- Wilate
  - FVIII 500 units and VWF:RCo 500 units
  - FVIII 1000 units and VWF:RCo 1000 units

*FDA Approved Indications:*

Alphanate is a FVIII/VWF complex/IV formulation indicated for:

- Hemophilia A:
  - Control and prevention of bleeding in adults and pediatric patients with hemophilia A.
- Von Willebrand disease:
  - Surgical and/or invasive procedures in adults and pediatric patients with von Willebrand Disease (VWD) in whom desmopressin (DDAVP) is either ineffective or contraindicated.

Humate-P is a FVIII/VWF complex/IV formulation indicated for:

- Hemophilia A:
  - Treatment and prevention of bleeding in adults with hemophilia A (classical hemophilia).
- Von Willebrand disease (VWD):
  - Treatment of spontaneous and trauma-induced bleeding episodes;
  - Prevention of excessive bleeding during and after surgery in patients with severe VWD as well as patients with mild or moderate disease where use of desmopressin (DDAVP) is known or suspected to be inadequate.

  Limitations of use: Controlled clinical trials to evaluate the safety and efficacy of prophylactic dosing with Humate-P to prevent spontaneous bleeding have not been conducted in VWD subjects.

Wilate is a FVIII/VWF complex/IV formulation indicated for:

- Von Willebrand disease:
  - In children and adults with von Willebrand disease (VWD) disease for:
    - On-demand treatment and control of bleeding episodes;
    - Perioperative management of bleeding.

  Limitations of use: Wilate is not indicated for the treatment of hemophilia A.

**Appendices**

**Appendix A: Abbreviation Key**

IV: intravenous
RCo: ristocetin cofactor
VWD: von Willebrand disease
VWF: von Willebrand factor

**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 |
|---|---|
| J7183 | Injection, von Willebrand factor complex (human), Wilate, 1 IU vWF:RCo |
| J7186 | Injection, antihemophilic factor VIII/von Willebrand factor complex (human), per factor VIII i.u. |
| J7187 | Injection, von Willebrand factor complex (Humate-P), per IU VWF:RCO |

| Reviews, Revisions, and Approvals | Date | Approval Date |
|---|---|---|
| Policy split from CP.PHAR.12.Blood Factors and converted to new template.<br>Removed requests for documentation. Removed indication for prophylaxis after 2 joint bleeds/approval period 6 months as there is no FDA approved indication for long-term prophylaxis. Approval period is edited to be 3 months initial and one 3-month re-auth as, in some circumstances, treatment could be necessary for up to six months (e.g., intracranial hemorrhage per Alphanate PI).<br>Reviewed by specialist. | 04/16 | 05/16 |
| Removed "major surgery" restriction for Alphanate. Required trial of desmopressin is edited to avoid necessity of testing for coagulation factors. Safety information removed. Uses and approval periods across all blood factor policies worded consistently. Efficacy statement added to renewal criteria. Hemophilias are specified as "congenital" versus "acquired" across blood factor policies where indicated. Reviewed by specialist-hematology/internal medicine | 04/17 | 05/17 |

**References**

1. Alphanate Prescribing Information. Los Angeles, CA: Grifols Biologicals Inc.; March 2015. Available at http://www.alphanate.com/documents/24721175/24744788/Alphanate+PI_Nav_Footer/ddecc393-94e6-43bc-aa92-9133b96dc960. Accessed April 26, 2017.
2. Humate-P Prescribing Information. Kankakee, IL: CSL Behring, LLC; June 2014. Available at http://labeling.cslbehring.com/PI/US/Humate-P/EN/Humate-P-Prescribing-Information.pdf. Accessed April 26, 2017.
3. Wilate Prescribing Information. Hoboken, NJ: Octapharma USA Inc.; August 2015. Available at http://www.wilateusa.com/images/PDF_Files/WILATE_FPI_US_additional_Perioperative_Indication_8_2015.pdf. Accessed April 26, 2017.
4. Human-plasma derived von Willebrand factor (contains factor VIII): Drug Information (Lexicomp). In: UpToDate, Waltham, MA: Walters Kluwer Health; 2017. Available at uptodate.com. Accessed April 26, 2017.
5. Srivastava A, Brewer AK, Mauser-Bunschoten EP, et al. Guidelines for the management of hemophilia. Haemophilia. Jan 2013; 19(1): e1-47.
6. Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation (NHF): Database of treatment guidelines. Available at https://www.hemophilia.org/Researchers-Healthcare-Providers/Medical-and-Scientific-Advisory-Council-MASAC/MASAC-Recommendations. Accessed April 28, 2017.

**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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

**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.