SPECIALTY GUIDELINE MANAGEMENT

IDELEVION (coagulation factor IX [recombinant], albumin fusion protein)

ALPROLIX (coagulation factor IX [recombinant], Fc fusion protein)

BENEFIX, IXINITY, RIXUBIS (coagulation factor IX [recombinant])

ALPHANINE SD, MONONINE (coagulation factor IX [human])

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication

Hemophilia B

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Hemophilia B

Indefinite authorization may be granted for treatment of hemophilia B.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

IV. REFERENCES