SPECIALTY GUIDELINE MANAGEMENT

FACTOR VIII CONCENTRATES

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.

Table: Factor VIII Concentrates and Covered Uses

<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>FDA-Approved Indication(s)</th>
<th>Compendial Indication(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recombinant Factor VIII Concentrates</strong></td>
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<tr>
<td>Advate</td>
<td>antihemophilic factor [recombinant]</td>
<td>Hemophilia A</td>
<td>Acquired Hemophilia A</td>
</tr>
<tr>
<td>Afstyla</td>
<td>antihemophilic factor [recombinant], single chain</td>
<td>Hemophilia A</td>
<td></td>
</tr>
<tr>
<td>Helixate FS</td>
<td>antihemophilic factor [recombinant]</td>
<td>Hemophilia A</td>
<td>Acquired Hemophilia A</td>
</tr>
<tr>
<td>Kogenate FS</td>
<td>antihemophilic factor [recombinant]</td>
<td>Hemophilia A</td>
<td>Acquired Hemophilia A</td>
</tr>
<tr>
<td>Kovaltry</td>
<td>antihemophilic factor [recombinant]</td>
<td>Hemophilia A</td>
<td></td>
</tr>
<tr>
<td>Novoeight</td>
<td>antihemophilic factor [recombinant]</td>
<td>Hemophilia A</td>
<td></td>
</tr>
<tr>
<td>Nuwiq</td>
<td>antihemophilic factor [recombinant]</td>
<td>Hemophilia A</td>
<td></td>
</tr>
<tr>
<td>Recombinate</td>
<td>antihemophilic factor [recombinant]</td>
<td>Hemophilia A</td>
<td>Acquired Hemophilia A</td>
</tr>
<tr>
<td>Xyntha</td>
<td>antihemophilic factor [recombinant]</td>
<td>Hemophilia A</td>
<td>Acquired Hemophilia A</td>
</tr>
<tr>
<td><strong>Extended Half-life Recombinant Factor VIII Concentrate</strong></td>
<td></td>
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<tr>
<td>Adynovate</td>
<td>antihemophilic factor [recombinant], PEGylated</td>
<td>Hemophilia A</td>
<td></td>
</tr>
<tr>
<td>Eloctate</td>
<td>antihemophilic factor [recombinant], Fc fusion protein</td>
<td>Hemophilia A</td>
<td></td>
</tr>
<tr>
<td>Jivi</td>
<td>antihemophilic factor [recombinant], PEGylated-auc</td>
<td>Hemophilia A</td>
<td></td>
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<tr>
<td><strong>Human Plasma-Derived Factor VIII Concentrates</strong></td>
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<tr>
<td>Hemofil M Monoclate-P</td>
<td>antihemophilic factor [human], monoclonal antibody purified</td>
<td>Hemophilia A</td>
<td>Acquired Hemophilia A</td>
</tr>
<tr>
<td><strong>Human Plasma-Derived Factor VIII Concentrates That Contain Von Willebrand Factor</strong></td>
<td></td>
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<tr>
<td>Humate-P</td>
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</tbody>
</table>
All other indications are considered experimental/investigational and are not a covered benefit.

CRITERIA FOR INITIAL APPROVAL

A. Hemophilia A
   Indefinite authorization of Advate, Adynovate, Afstyla, Alphanate, Eloctate, Helixate FS, Hemofil M, Humate-P, Koate, Kogenate FS, Kovaltry, Monoclate-P, Novoeight, Nuwiq, Recombinate or Xyntha may be granted for treatment of hemophilia A when either of the following criteria is met:
   1. Member has mild disease (see Appendix A) and has had an insufficient response to desmopressin or a documented clinical reason for not using desmopressin (see Appendix B).
   2. Member has moderate or severe disease (see Appendix A).

   Indefinite authorization of Jivi may be granted for treatment of hemophilia A when both of the following criteria are met:
   1. Member has previously received treatment for hemophilia A with a factor VIII product.
   2. Member is ≥ 12 years of age.

B. Von Willebrand Disease
   Indefinite authorization of Alphanate, Humate-P or Koate may be granted for treatment of vWD when any of the following criteria is met:
   1. Member has type 1, 2A, 2M, or 2N vWD and has had an insufficient response to desmopressin or a documented clinical reason for not using desmopressin (see Appendix B).
   2. Member has type 2B or type 3 vWD.

C. Acquired Hemophilia A
   Indefinite authorization of Advate, Alphanate, Helixate FS, Hemofil M, Humate-P, Koate, Kogenate FS, Monoclate-P, Recombinate or Xyntha or may be granted for treatment of acquired hemophilia A.

D. Acquired von Willebrand Syndrome
   Indefinite authorization of Alphanate or Humate-P may be granted for treatment of acquired von Willebrand syndrome.

II. CONTINUATION OF THERAPY

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

III. APPENDICES
Appendix A: Classification of Hemophilia by Clotting Factor Level (% Activity) and Bleeding Episodes

<table>
<thead>
<tr>
<th>Severity</th>
<th>Clotting Factor Level % activity*</th>
<th>Bleeding Episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe</td>
<td>&lt;1%</td>
<td>Spontaneous bleeding episodes, predominantly into joints and muscles</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Severe bleeding with trauma, injury or surgery</td>
</tr>
<tr>
<td>Moderate</td>
<td>1% to 5%</td>
<td>Occasional spontaneous bleeding episodes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Severe bleeding with trauma, injury or surgery</td>
</tr>
<tr>
<td>Mild</td>
<td>6% to 40%</td>
<td>Severe bleeding with serious injury, trauma or surgery</td>
</tr>
</tbody>
</table>

*Factor assay levels are required to determine the diagnosis and are of value in monitoring treatment response.

Appendix B: Clinical Reasons For Not Utilizing Desmopressin in Patients with Hemophilia A and Type 1, 2A, 2N and 2M vWD

A. Age < 2 years
B. Pregnancy
C. Fluid/electrolyte imbalance
D. High risk for cardiovascular or cerebrovascular disease (especially the elderly)
E. Predisposition to thrombus formation
F. Trauma requiring surgery
G. Life-threatening bleed
H. Contraindication or intolerance to desmopressin
I. Severe type 1 von Willebrand disease

IV. REFERENCES


