Hemophilia Products – Anti-Inhibitor Antibody: Hemlibra (emicizumab-kxwh) (Subcutaneous)

Effective date: 01/01/2020

Review date: 12/18/19, 1/22/20, 2/25/2021, 06/24/2021, 6/16/2022, 6/22/2023, 12/07/2023, 01/04/2024, 05/15/2024, 08/14/2024

Scope: Medicaid, Commercial, Medicare-Medicaid Plan (MMP)

I. Length of Authorization

Unless otherwise specified*, the initial authorization will be provided for 3 months and may be renewed every 12 months thereafter.

Note: The cumulative amount of medication the patient has on-hand will be taken into account for authorizations.

** Initial and renewal authorization periods may vary by specific covered indication*

II. Dosing Limits

A. Quantity Limit (max daily dose) [Pharmacy Benefit]:

Loading Dose: • 345mg weekly x 4 doses
Maintenance Dose: • 1.5mg/kg weekly = 180mg weekly • 3mg/kg every 2 weeks = 345mg every 2 weeks • 6mg/kg every 4 weeks = 690mg every 4 weeks

B. Max Units (per dose and over time) [Medical Benefit]:

Loading Dose: • 690 billable units (BU) weekly x 4 doses
Maintenance Dose: • 1.5mg/kg weekly = 360 BU weekly • 3mg/kg every 2 weeks = 690 BU every 2 weeks • 6mg/kg every 4 weeks = 1380 BU every 4 weeks

Note: Patient must be dosed at a frequency that will produce the least wastage per dose based on available vial sizes of 30 mg, 60 mg, 105 mg, 150 mg, and 300mg.

III. Summary of Evidence

Hemlibra is a factor IXa and X indicated for the routine prophylaxis to prevent or reduce the frequency of bleeding episodes in patients with hemophilia A. Efficacy in patients with hemophilia A without FVIII inhibitors was established in two clinical trials, Haven 3 and Haven 4. Haven 3 was a randomized, multicenter, open-label, clinical trial in 152 patients with hemophilia A who received on-demand or prophylactic treatment. Patients received Hemlibra 3mg/kg once weekly for the first 4 weeks followed by either 1.5mg/kg once weekly or 3mg/kg once every two weeks or no prophylaxis. Hemlibra prophylaxis resulted in a statistically significant ($p<0.0001$) 68% reduction in bleed rate for treated bleeds compared to previous FVIII prophylaxis as well as significant reductions observed in all bleeds, spontaneous bleeds, joint bleeds and target joint bleeds. Haven 4 was a single-arm, multicenter, open-label clinical trial that included 41 patients with hemophilia A, with or without FVIII inhibitors. Patients received 3mg/kg weekly for the first 4 weeks followed by 6 mg/kg once every four weeks thereafter. Results show an annualized bleed rate of 1.2 for treated bleeds with four patients experiencing zero treated bleeds, demonstrating efficacy in reducing bleed rate. Adverse effects include injection site reactions, headache and arthralgia.

IV. Initial Approval Criteria

- MMP members who have previously received this medication within the past 365 days are not subject to Step Therapy Requirements.

Hemophilia A (congenital factor VIII deficiency) with inhibitors † Φ

- Diagnosis of congenital factor VIII deficiency has been confirmed by blood coagulation testing; **AND**
- Patient has inhibitors to Factor VIII with a current or historical titer of ≥ 5 Bethesda Units (BU)**** ; **AND**
- Must be used as routine prophylaxis to prevent or reduce the frequency of bleeding episodes; **AND**
    - Used as primary prophylaxis in patients with severe factor VIII deficiency (factor VIII level of <1%); **OR**
    - Used as secondary prophylaxis in patients with at least TWO documented episodes of spontaneous bleeding into joints; **AND**
    -
- Not used in combination with Immune Tolerance Induction (ITI); **AND**
    - Patient has at least two documented episodes of spontaneous bleeding into joints; **OR**
    - Patient has documented trial and failure of Immune Tolerance Induction (ITI); **OR**
    - Patient has documented trial and failure of or is currently on routine prophylaxis with a bypassing agent (i.e., NovoSeven, FEIBA).

***Note:** Patients with inhibitor titer levels >0.6 BU to <5 BU who are not responding to or are not a candidate for standard factor replacement, will be evaluated on a case-by-case basis.*

Hemophilia A (congenital factor VIII deficiency) without inhibitors † Φ

- Diagnosis of congenital factor VIII deficiency has been confirmed by blood coagulation testing; **AND**
- Used for routine prophylaxis to prevent or reduce the frequency of bleeding episodes; **AND**
- Used as treatment in one of the following:
    - Primary prophylaxis in patients with severe factor VIII deficiency (factor VIII level of <1%); **OR**
    - Secondary prophylaxis in patients with at least TWO documented episodes of spontaneous bleeding into joints; **AND**
- Patient is not a suitable candidate for treatment with shorter half-life Factor VIII (recombinant) products at a total weekly dose of 100 IU/kg or less (as attested by the prescribing physician with appropriate clinical rationale)

† FDA Approved Indication(s); ‡ Compendia Recommended Indication(s); **Φ** Orphan Drug

V. Dispensing Requirements for Rendering Providers (Hemophilia Management Program)

- Prescriptions cannot be filled without an expressed need from the patient, caregiver or prescribing practitioner. Auto-filling is not allowed.
- Monthly, rendering provider must submit for authorization of dispensing quantity before delivering factor product.
- The cumulative amount of medication(s) the patient has on-hand should be taken into account when dispensing factor product.
- Dispensing requirements for renderings providers are a part of the hemophilia management program. This information is not meant to replace clinical decision making when initiating or modifying medication therapy and should only be used as a guide.

VI. Renewal Criteria

Coverage can be renewed based upon the following criteria:

- Patient continues to meet criteria identified in section III; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: thrombotic microangiopathy thromboembolic events (thromboembolism, pulmonary embolism), development of neutralizing antibodies (inhibitors), etc.; **AND**
- Any increases in dose must be supported by an acceptable clinical rationale (i.e. weight gain, half-life study results, increase in breakthrough bleeding when patient is fully adherent to therapy, etc.); **AND**
- Patient has demonstrated a beneficial response to therapy (i.e., the frequency of bleeding episodes has decreased from pre-treatment baseline); **AND**

- The cumulative amount of medication(s) the patient has on-hand will be taken into account when authorizing.

Routine prophylaxis to prevent or reduce the frequency of bleeding episode

- Renewals will be approved for a 12 month authorization period

Dosage/Administration

Indication	Dose
Routine Prophylaxis in Congenital Hemophilia A with or without inhibitors	3 mg/kg by subcutaneous injection once weekly for the first 4 weeks, followed by 1.5 mg/kg once weekly, 3 mg/kg every two weeks, or 6 mg/kg every four weeks

VII. Billing Code/Availability Information

HCPCS Code:

- J7170 - Injection, emicizumab-kxwh, 0.5 mg; 1 billable unit = 0.5 mg

NDC:

Drug	Strength	Form	NDC
	12mg/0.4 mL	SDV	50242-0927-xx
Hemlibra	30 mg/mL	SDV	50242-0920-xx
	60 mg/0.4 mL	SDV	50242-0921- xx
	105 mg/0.7 mL	SDV	50242-0922- xx
	150 mg/mL	SDV	50242-0923- xx
	300 mg/2 mL	SDV	50242-0930-xx

VIII. References

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Appendix 1 – Covered Diagnosis Codes

Hemlibra

ICD-10	ICD-10 Description
D66	Hereditary factor VIII deficiency

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/search.aspx. Additional indications may be covered at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD/LCA):

Jurisdiction(s): N	**NCD/LCD Document (s):** A56482
https://www.cms.gov/medicare-coverage-database/new-search/search-results.aspx?keyword=a56482&areaId=all&docType=NCA%2CCAL%2CNCD%2CMEDCAC%2CTA%2CMCD%2C6%2C3%2C5%2C1%2CF%2CP	
Jurisdiction(s): J,M	**NCD/LCD Document (s):** A56065
https://www.cms.gov/medicare-coverage-database/new-search/search-results.aspx?keyword=a56065&areaId=all&docType=NCA%2CCAL%2CNCD%2CMEDCAC%2CTA%2CMCD%2C6%2C3%2C5%2C1%2CF%2CP	

Jurisdiction(s): H,L	**NCD/LCD Document (s):** A56433
https://www.cms.gov/medicare-coverage-database/new-search/search-results.aspx?keyword=a56433&areaId=all&docType=NCA%2CCAL%2CNCD%2CMEDCAC%2CTA%2CMCD%2C6%2C3%2C5%2C1%2CF%2CP	

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD): N/A

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA, LLC
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA, LLC
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC

Policy Rationale: Hemlibra was reviewed by the Neighborhood Health Plan of Rhode Island Pharmacy & Therapeutics (P&T) Committee. Neighborhood adopted the following clinical coverage criteria to ensure that its members use Hemlibra according to Food and Drug Administration (FDA) approved labeling and/or relevant clinical literature. Neighborhood worked with network prescribers and pharmacists to draft these criteria. These criteria will help ensure its members are using this drug for a medically accepted indication, while minimizing the risk for adverse effects and ensuring more cost-effective options are used first, if applicable and appropriate. For INTEGRITY (Medicare-Medicaid Plan) members, these coverage criteria will only apply in the absence of National Coverage Determination (NCD) or Local Coverage Determination (LCD) criteria. Neighborhood will give individual consideration to each request it reviews based on the information submitted by the prescriber and other information available to the plan.