Drug Coverage Policy

Effective Date.....01/15/2025
Coverage Policy Number.....IP0564
Policy Title.....Altuviiio

Hemophilia – Altuviiio

- Altuviiio™ (antihemophilic factor [recombinant] Fc-VWF-XTEN fusion protein-ehtl intravenous infusion - Bioverativ/Sanofi)

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment and have discretion in making individual coverage determinations. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Cigna Healthcare Coverage Policy

Altuviiio, a recombinant DNA-derived Factor VIII concentrate, is indicated for use in **hemophilia A** in adults and children for:[1]

- **Routine prophylaxis** to reduce the frequency of bleeding episodes.
- **On-demand treatment and control** of bleeding episodes.
- **Perioperative management** of bleeding.

It is notable that Altuviiio has demonstrated a 3- to 4-fold prolonged half-life relative to other standard and extended half-life products.[1]

Disease Overview
Hemophilia A is an X-linked bleeding disorder primarily impacting males caused by a deficiency in Factor VIII.[2-5] In the US, the incidence of hemophilia A in males is 1:5,000 with an estimated 20,000 people in the US living with hemophilia A. The condition is characterized by bleeding in joints, either spontaneously or in a provoked joint by trauma. Bleeding can occur in many different body areas as well (e.g., muscles, central nervous system). The bleeding manifestations can lead to substantial morbidity such as hemophilic arthropathy. Disease severity is usually defined by the plasma levels or activity of Factor VIII classified as follows: severe (levels < 1% of normal), moderate (levels 1% to 5% of normal), and mild (levels > 5% to < 40% of normal); phenotypic expression may vary. Approximately 50% of patients with hemophilia A are categorized as having severe disease.

Guidelines
Guidelines have not addressed Altuviiio. Guidelines for hemophilia from the National Hemophilia Foundation (March 2023)[6] and the World Federation of Hemophilia (2020)[7] recognize the important role of Factor VIII products and Hemlibra® (emicizumab-kxwh subcutaneous injection) in the management of hemophilia A in patients. The National Bleeding Disorders Foundation recognize Altuviiio as a product with a prolonged half-life.

Dosing Considerations
Dosing of clotting factor concentrates is highly individualized. The National Hemophilia Foundation's Medical and Scientific Advisory Council (MASAC) provides recommendations regarding doses of clotting factor concentrate in the home (2016).[8] The number of required doses varies greatly and is dependent on the severity of the disorder and the prescribed regimen. Per MASAC guidance, patients on prophylaxis should also have a minimum of one major dose and two minor doses on hand for breakthrough bleeding in addition to the prophylactic doses used monthly. The guidance also notes that an adequate supply of clotting factor concentrate is needed to accommodate weekends and holidays. Therefore, maximum doses in this policy allow for prophylactic dosing plus three days of acute bleeding or perioperative management per 28 days. Doses exceeding this quantity will be reviewed on a case-by-case basis by a clinician.

Medical Necessity Criteria

Altuviiio is considered medically necessary when the following is met:

FDA-Approved Indication

1. **Hemophilia A.** Approve for 1 year if the patient meets ONE of the following (A or B):
   - **A)** Initial Therapy. Approve if the patient meets ALL of the following (i, ii, and iii):
     - **i.** Altuviiio is being used in at least ONE of the following scenarios (a, b, or c).
       - **a)** Routine prophylaxis; OR
       - **b)** On-demand treatment and control of bleeding episodes; OR
       - **c)** Perioperative management of bleeding; AND
     - **ii.** Patient meets ONE of the following (a or b):
       - **a)** Patient meets BOTH of the following [(1) and (2)]:
         - **(1)** Factor VIII inhibitor testing has been performed within the past 30 days; AND
         - **(2)** Patient does not have a positive test for Factor VIII inhibitors ≥ 1.0 Bethesda units/mL; OR

b) Patient has not received Factor VIII therapy in the past; AND

iii. Medication is prescribed by or in consultation with a hemophilia specialist; OR

B) Patient is Currently Receiving Altuviiio or Has Received Altuviiio in the Past. Approve if the patient meets the ALL of following (i, ii, and iii):

i. Altuviiio is being used in at least ONE of the following scenarios (a, b, or c):

a) Routine prophylaxis; OR

b) On-demand treatment and control of bleeding episodes; OR

c) Perioperative management of bleeding; AND

ii. Patient meets ONE of the following (a or b):

a) Patient meets BOTH of the following (1 and 2):

(1) Factor VIII inhibitor testing has been performed within the past 365 days; AND

(2) Patient does not have a positive test for Factor VIII inhibitors ≥ 0.6 Bethesda units/mL; OR

b) According to the prescriber, patient does not have clinical manifestations suggesting the presence of Factor VIII inhibitors; AND

Note: Inhibitors may be present if bleeding is not well controlled, there is decreased responsiveness to Factor VIII therapy, and/or if expected Factor VIII activity plasma levels are not achieved.

iii. Medication is prescribed by or in consultation with a hemophilia specialist.

Dosing. Approve the following dosing regimens (A, B, and/or C):

A) Routine prophylaxis: approve up to 50 IU per kg intravenously no more frequently than once weekly; AND/OR

B) On demand treatment and control of bleeding episodes: approve up to 50 IU per kg intravenously with additional doses once every 2 to 3 days for up to 10 days per episode; AND/OR

C) Perioperative management of bleeding: approve up to 50 IU per kg intravenously and provide for additional doses once every 2 to 3 days for up to 10 days per procedure.

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Conditions Not Covered

Any other use is considered experimental, investigational, or unproven (criteria will be updated as new published data are available).

Coding Information

1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

HCPCS Codes	Description
J7205	Injection, Factor VIII Fc fusion protein (recombinant), per IU

References

1. Altuviiio™ intravenous infusion [prescribing information]. Waltham, MA: Bioverativ/Sanofi; March 2023.
2. Mancuso ME, Mahlangu JN, Pipe SW. The changing treatment landscape in haemophilia: from standard half-life clotting factor concentrates to gene editing. *Lancet*. 2021;397:630-640.
3. Croteau SE. Hemophilia A/B. *Hematol Oncol Clin North Am*. 2022;36(4):797-812.
4. Franchini M, Mannucci PM. The more recent history of hemophilia treatment. *Semin Thromb Hemost*. 2022;48(8):904-910.
5. Peyvandi F, Garagiola I, Young G. The past and future of haemophilia: diagnosis, treatments and its complications. *Lancet*. 2016;388(10040):187-197.
6. National Bleeding Disorders Foundation. MASAC (Medical and Scientific Advisory Council) recommendations concerning products licensed for the treatment of hemophilia and selected disorders of the coagulation system (Revised August 2023). MASAC Document #280. Endorsed on August 20, 2023. Available at: https://www.hemophilia.org/sites/default/files/document/files/MASAC-Products-Licensed.pdf. Accessed on February 21, 2024.
7. Srivastava A, Santagostino E, Dougall A, et al, on behalf of the WFH guidelines for the management of hemophilia panelists and coauthors. WFH guidelines for the management of hemophilia, 3rd edition. *Haemophilia*. 2020;26(Suppl 6):1-158.
8. National Hemophilia Foundation. MASAC (Medical and Scientific Advisory Council) recommendations regarding doses of clotting factor concentrate in the home (Revised June 7, 2016). MASAC Document #242. Adopted on September 3, 2020. Available at: https://www.hemophilia.org/sites/default/files/document/files/242.pdf. Accessed on February 21, 2024.

Revision Details

Type of Revision	Summary of Changes	Date
Annual Revision	**Updated** the scenarios for Altuviiio use. **Added** Factor VIII testing requirements. **Updated** the specialist prescribing requirement. **Added** criteria for a patient currently receiving Altuviiio or has received Altuviiio in the past.	08/15/2024
Selected Revision	In Hemophilia A, for Initial therapy, the threshold for a positive inhibitor test was changed to ≥ 1.0 Bethesda units/mL; previously, it was ≥ 0.6 Bethesda units/mL. It was added that a patient who has not received Factor VIII therapy in the past is not required to meet the inhibitor testing requirements. For a Patient Currently Receiving Altuviiio or has received Altuviiio in the past, the Factor VIII	01/15/2025

	inhibitor testing timeframe was changed to within the past 365 days; previously, the timeframe was within the last 30 days. The wording "prescribing physician" was replaced with "prescriber".	

The policy effective date is in force until updated or retired.

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