

Hemophilia Products – Anti-Inhibitor Coagulant Complex:

Feiba

(Intravenous)

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I. Length of Authorization

Coverage is provided for 3 months and may be renewed thereafter, unless otherwise specified*

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) [NDC unit]:

- Feiba 500 IU (Orange) single-dose vial: 293 vials per 30-day supply
- Feiba 1000 IU (Green) single-dose vial: 147 vials per 30-day supply
- Feiba 2500 IU (Purple) single-dose vial: 59 vials per 30-day supply

B. Max Units (per dose and over time) [HCPCS Unit]:

- 146,625 billable units per 30 day supply

III. Initial Approval Criteria ^{1-3,8-11}

Coverage is provided in the following conditions:

Hemophilia A (congenital factor VIII deficiency) † Φ

- Diagnosis of congenital factor VIII deficiency has been confirmed by blood coagulation testing; **AND**
- Confirmation the patient has inhibitors to Factor VIII; **AND**
- Used as treatment in at least one of the following:
 - Control and prevention of acute bleeding episodes (episodic treatment of acute hemorrhage); **OR**
 - Perioperative management (**Authorizations valid for 1 month*); **OR**

- Routine prophylaxis to prevent or reduce the frequency of bleeding episodes; **AND**
 - Patient has at least two documented episodes of spontaneous bleeding into joints; **OR**
- Patient has a documented trial and failure of Immune Tolerance Induction (ITI); **AND**
 - Patient has a documented trial and failure or contraindication to emicizumab-kxwh therapy.

Hemophilia B (congenital factor IX deficiency aka Christmas disease) † Φ

- Diagnosis of congenital factor IX deficiency has been confirmed by blood coagulation testing; **AND**
- Confirmation the patient has inhibitors to Factor IX; **AND**
- Used as treatment in at least one of the following:
 - Control and prevention of acute bleeding episodes (episodic treatment of acute hemorrhage); **OR**
 - Perioperative management (**Authorizations valid for 1 month*); **OR**
 - Routine prophylaxis to prevent or reduce the frequency of bleeding episodes; **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)

† FDA Approved Indication(s); Φ Orphan Drug

IV. 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. Information submitted must include:
 - Original prescription information, requested amount to be dispensed, vial sizes available to be ordered from the manufacturer, and patient clinical history (including patient product inventory and bleed history)
 - Factor dose should not exceed +1% of the prescribed dose and a maximum of three vials may be dispensed per dose. If unable to provide factor dosing within the required threshold, below the required threshold, the lowest possible dose able to be achieved above +1% should be dispensed. Prescribed dose should not be increased to meet assay management requirements.
- The cumulative amount of medication(s) the patient has on-hand should be taken into account when dispensing factor product. Patients should not have more than 5 extra doses on-hand for the treatment of acute bleeding episodes.

- 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.

V. Renewal Criteria ^{1-3,8}

Coverage can be renewed based upon the following criteria:

- Patient continues to meet indication-specific relevant criteria identified in section III; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: symptoms of allergic-anaphylactic reactions (anaphylaxis, dyspnea, rash, etc.), thromboembolic events (venous thrombosis, pulmonary embolism, myocardial infarction, stroke, etc.), 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**
- The cumulative amount of medication(s) the patient has on-hand will be taken into account when authorizing. The authorization will allow up to 5 doses on-hand for the treatment of acute bleeding episodes as needed for the duration of the authorization; **AND**

Treatment of acute bleeding episodes/Treatment of Spontaneous and trauma-induced bleeding episodes/On-demand treatment of bleeding episodes

- Renewals will be approved for a 6 month authorization period

Prevention of acute bleeding episodes/Routine prophylaxis to prevent or reduce the frequency of bleeding episodes

- Renewals will be approved for a 12 month authorization period; **AND**
- Patient has demonstrated a beneficial response to therapy (i.e., the frequency of bleeding episodes has decreased from pre-treatment baseline)

Dosage/Administration¹⁻³

Indication	Dose
Control and prevention of bleeding Congenital Hemophilia A / Hemophilia B with inhibitors	<u>Joint hemorrhage</u> Administer 50—100 units/kg IV every 12 hours until pain and acute disabilities are improved
	<u>Mucous Membrane Bleeding</u> Administer 50—100 units/kg IV every 6 hours for at least 1 day or until bleeding is resolved
	<u>Soft tissue hemorrhage</u> Administer 100 units/kg IV every 12 hours until resolution of bleed
	<u>Other severe hemorrhage</u> Administer 100 units/kg IV every 6—12 hours until resolution of bleed

Indication	Dose
Routine Prophylaxis Congenital Hemophilia A/ Hemophilia B with inhibitors	Administer 85 units/kg IV every other day
Perioperative management Congenital Hemophilia A / Hemophilia B with inhibitors	<u>Preoperative</u> Administer 50—100 units/kg IV administered as a 1 time dose immediately prior to surgery <u>Postoperative</u> Administer 50 – 100 units/kg IV administered every 6 – 12 hours postoperatively until resolution of bleed and healing is achieved

VI. Billing Code/Availability Information

HCPCS Code & NDC:

Drug	Manufacturer	HCPCS Code	1 Billable Unit Equiv.	Vial Size	NDC
Feiba	Baxalta US Inc	J7198	1 IU	500 units	64193-0426-xx
				1000 units	64193-0424- xx
				2500 units	64193-0425- xx

VII. References

1. Feiba [package insert]. Lexington, MA; Baxalta US Inc. February 2020. Accessed April 2022.
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7. Mingot-Castellano, et al. Application of Pharmacokinetics Programs in Optimization of Haemostatic Treatment in Severe Hemophilia a Patients: Changes in Consumption, Clinical Outcomes and Quality of Life. Blood. 2014 December; 124 (21).

8. MASAC RECOMMENDATION CONCERNING PROPHYLAXIS. 2016 National Hemophilia Foundation. MASAC Document #241; February 2016. Available at: <http://www.hemophilia.org>. Accessed August 2022.
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12. First Coast Service Options, Inc. Local Coverage Article: Billing and Coding: Hemophilia Clotting Factors (A56482). Centers for Medicare & Medicaid Services Inc. Updated on 02/05/2021 with effective date 01/01/2021. Accessed April 2022.
13. Palmetto GBA. Local Coverage Article: Billing and Coding: Guidance for Anti-Inhibitor Coagulant Complex (AICC) National Coverage Determination (NCD) 110.3 (A56065). Centers for Medicare & Medicaid Services Inc. Updated on 02/01/2021 with effective date 01/01/2021. Accessed April 2022.
14. Novitas Solutions, Inc. Local Coverage Article: Billing and Coding: Hemophilia Factor Products (A56433). Centers for Medicare & Medicaid Services Inc. Updated on 05/07/2021 with effective date 04/08/2021. Accessed April 2022.

Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
D66	Hereditary factor VIII deficiency
D67	Hereditary factor IX 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 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)
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

Nondiscrimination & Language Access Policy

Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. We do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

We will:

Provide free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact us at the phone number shown on the inside cover of this contract, your id card, or aspirushealthplan.com.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with:

Nondiscrimination Grievance Coordinator
Aspirus Health Plan, Inc.
PO Box 1062
Minneapolis, MN 55440
Phone: 1.866.631.5404 (TTY: 711)
Fax: 763.847.4010
Email: customerservice@aspirushealthplan.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Nondiscrimination Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language Assistance Services

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1.866.631.5404 (TTY: 711).

Arabic: تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بن اعلى رقم الهاتف 1.866.631.5404 (رقم هاتف الصم والبك : 711)

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelezle 1.866.631.5404 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.866.631.5404 (TTY: 711).

Hindi: _यान द_ : य_द आप िहंदी बोलते ह_ तो आपके िलए मु_त म_ भाषा सहायता सेवाएं उपल_ध ह_। 1.866.631.5404 (TTY: 711) पर कॉल कर_।

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.866.631.5404 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.866.631.5404 (TTY: 711)번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.866.631.5404 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.866.631.5404 (телетайп: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.866.631.5404 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1.866.631.5404 (TTY: 711)

Traditional Chinese: 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1.866.631.5404 (TTY:711)。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.866.631.5404 (TTY: 711).

Pennsylvania Dutch: Wann du Deitsch (Pennsylvania German / Dutch) schwetzsch, kannscht du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.866.631.5404 (TTY: 711).

Lao: ໄປ່ດຊາຍ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1.866.631.5404 (TTY:711).