

# Hemophilia Products – Factor XIII: Corifact® (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. Up to 5 'on-hand' doses for the treatment of acute bleeding episodes will be permitted at the time of the authorization request.*

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

## II. Dosing Limits

### A. Quantity Limit (max daily dose) [NDC Unit]:

- Corifact 1000-1600 IU vial: 5 vials per 28-day supply

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

- 4,600 billable units per 28 day supply

## III. Initial Approval Criteria <sup>1-3,8</sup>

### Hemophilia Management Program

Requirements for half-life study and inhibitor tests 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.

Coverage is provided in the following conditions:

### Congenital Factor XIII deficiency † Φ

- Diagnosis of congenital factor XIII deficiency has been confirmed by blood coagulation testing; **AND**
  - Used for routine prophylactic treatment; **OR**

- Used for perioperative management of surgical bleeding (*\*Authorizations valid for 1 month*)

Hemophilia Management Program
<ul style="list-style-type: none"> <li>● If the request is for routine prophylaxis and the requested dose exceeds dosing limits under part II, a half-life study should be performed to determine the appropriate dose and dosing interval.</li> <li>● For members with a BMI <math>\geq 30</math>, a half-life study should be performed to determine the appropriate dose and dosing interval.</li> <li>● For minimally treated patients (&lt; 50 exposure days to factor products) previously receiving a different factor product, inhibitor testing is required at baseline, then at every comprehensive care visit (yearly for the mild and moderate patients, semi-annually for the severe patients)</li> </ul>

† FDA Approved Indication(s); Ⓞ 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 <sup>1-3,8</sup>

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 (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**
- 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**

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

- 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)

## VI. Dosage/Administration <sup>1-3</sup>

Indication	Dose
Routine prophylaxis for bleeding Congenital factor XIII deficiency	40 International Units (IU) per kg body weight at a rate not to exceed 4 mL per minute, given every 28 days. Adjust dose $\pm$ 5 IU per kg to maintain 5% to 20% trough level of FXIII activity.
Perioperative management Congenital factor XIII deficiency	40 International Units (IU) per kg body weight at a rate not to exceed 4 mL per minute.  Dosing should be individualized based on the patient's FXIII activity level, type of surgery, and clinical response. Monitor patient's FXIII activity levels during and after surgery. Dose adjustment will need to be made depending on when last prophylactic dose was given. <ul style="list-style-type: none"> <li>▪ Within 7 days – Additional dose may not be needed</li> <li>▪ 8-21 days - Additional partial or full dose may be needed based on FXIII activity level</li> <li>▪ 21-28 days - Full prophylactic dose</li> </ul>

## VII. Billing Code/Availability Information

HCPCS Code & NDC:

Drug	Manufacturer	HCPCS Code	1 Billable Unit Equiv.	Vial Size	NDC
Corifact	CSL Behring LLC	J7180	1 IU	1000-1600 units	63833-0518

## VIII. References

1. Corifact [package insert]. Kankakee, IL; CSL Behring LLC; September 2020. Accessed April 2022.
2. MASAC Recommendations Concerning Products Licensed For The Treatment Of Hemophilia And Other Bleeding Disorders. August 2020 National Hemophilia Foundation.

MASAC Document #263; August 2020. Available at: <http://www.hemophilia.org>. Accessed April 2022.

3. Guidelines for the Management of Hemophilia. 3rd Edition. World Federation of Hemophilia. 2020. Available at: <https://www1.wfh.org/publications/files/pdf-1863.pdf>. Accessed April 2022.
4. Annual Review of Factor Replacement Products. Oklahoma Health Care Authority Review Board. Updated April 2016. Accessed April 2022.
5. Graham A1, Jaworski K. Pharmacokinetic analysis of anti-hemophilic factor in the obese patient. Haemophilia. 2014 Mar;20(2):226-9.
6. Croteau SE1, Neufeld EJ. Transition considerations for extended half-life factor products. Haemophilia. 2015 May;21(3):285-8.
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 April 2022.
9. Rayment R, Chalmers E, Forsyth K, et al. Guidelines on the use of prophylactic factor replacement for children and adults with Haemophilia A and B. B J Haem:190;5,Sep2020. <https://doi.org/10.1111/bjh.16704>. Accessed April 2022.
10. 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.
11. 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
D68.2	Hereditary deficiency of other clotting factors

## 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 Articles (LCAs) and Local Coverage Determinations (LCDs) 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/LCA/LCD):

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

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

<b>Medicare Part B Administrative Contractor (MAC) Jurisdictions</b>		
<b>Jurisdiction</b>	<b>Applicable State/US Territory</b>	<b>Contractor</b>
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](http://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](mailto: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).