Clinical Policy: Marstacimab-hncq (Hympavzi)

Reference Number: CP.PHAR.674
Effective Date: 10.11.24
Last Review Date: 02.25
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Marstacimab-hncq (Hympavzi™) is a tissue factor pathway inhibitor (TFPI) antagonist.

FDA Approved Indication(s)

Hympavzi is indicated for routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adult and pediatric patients 12 years of age and older with:

- hemophilia A (congenital factor VIII [FVIII] deficiency) without FVIII inhibitors, or
- hemophilia B (congenital factor IX [FIX] deficiency) without FIX inhibitors.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Hympavzi is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Congenital Hemophilia A or B (must meet all)**:**

1. Prescribed for routine prophylaxis of bleeding episodes in members with one of the following (a or b):
   a. Congenital hemophilia A (FVIII deficiency);
   b. Congenital hemophilia B (FIX deficiency);
2. Prescribed by or in consultation with a hematologist;
3. Age ≥ 12 years;
4. Member meets one of the following (a, b, or c):
   a. For hemophilia A: Member has severe hemophilia, defined as FVIII level of < 1%;
   b. For hemophilia B: Member has moderately severe to severe hemophilia, defined as FIX level of ≤ 2%;
   c. Member has experienced at least one serious spontaneous bleed (*see Appendix D*);
5. One of the following (a or b; *see Appendix D*):
   a. For hemophilia A, both (i and ii):
      i. Failure of a FVIII product used for routine prophylaxis as assessed and documented by prescriber, unless clinically significant adverse effects are experienced or all are contraindicated;*
      ii. Failure of Hemlibra® as assessed and documented by prescriber, unless contraindicated or clinically significant adverse effects are experienced;*

b. For hemophilia B: Failure of a FIX product used for routine prophylaxis as assessed and documented by prescriber, unless clinically significant adverse effects are experienced or all are contraindicated;*

**Prior authorization may be required for FVIII products, FIX products, and Hemlibra*

6. No documented history of inhibitors;
7. Provider confirms that member will discontinue any use of FVIII or FIX products as prophylactic therapy while on Hympavzi (on-demand usage may be continued);
8. Dose does not exceed both (a and b):
   a. Loading dose of 300 mg (2 pens or syringes);
   b. Maintenance dose of 150 mg (1 pen or syringe) per week thereafter.

Approval duration:
Medicaid/HIM – 6 months *(12 months for HIM Texas)*
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Congenital Hemophilia A or B (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B)*;
2. Member is responding positively to therapy (e.g., reduction in the number of all bleeds, joint bleeds, and/or target joint bleeds over time);
3. Provider confirms that member has discontinued any use of FVIII or FIX products as prophylactic therapy while on Hympavzi (on-demand usage may be continued);
4. If request is for a dose increase, new maintenance dose does not exceed:
   a. 150 mg (1 pen or syringe) per week;

b. 300 mg (2 pens or syringes) per week AND documentation of both (i and ii):
   i. Member's weight ≥ 50 kg;
   ii. Control of bleeding events on a maintenance dose of 150 mg per week is judged to be inadequate by the provider.

Approval duration:
Medicaid/HIM – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
FIX: factor IX
FVIII: factor VIII
TFPI: tissue factor pathway inhibitor

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen
Non-factor product for routine prophylaxis in hemophilia A	
Hemlibra® (emicizumab-kxwh)	Loading dose of 3 mg/kg SC weekly for four weeks, followed by a maintenance dose of 1.5 mg/kg SC

Drug Name	Dosing Regimen
	weekly or 3 mg/kg once every two weeks or 6 mg/kg once every four weeks
FVIII products for routine prophylaxis in hemophilia A - examples	
Advate®, Adynovate®, Afstyla®, Altuviiio®, Eloctate®, Esperoct®, Jivi®, Helixate FS®, Kogenate FS®, Kovaltry®, Novoeight®, Nuwiq®,	See individual Prescribing Information for dosing regimen
FIX products for routine prophylaxis in hemophilia B - examples	
Alprolix®, BeneFIX®, Idelvion®, Ixinity®, Rebinyn®, Rixubis®	See individual Prescribing Information for dosing regimen

Appendix C: Contraindications/Boxed Warnings
None reported

Appendix D: General Information
- There are no strict criteria for failing factor product or Hemlibra for routine prophylaxis; however, the following reasons are acceptable to fulfill the criteria:
  - Prescriber has documented clinical criteria which support his or her assessment that the member has failed factor or Hemlibra therapy.
  - Clinically significant bleeding, hemarthroses, life-threatening bleeding episodes, joint swelling, upcoming surgery/procedure not responding to current therapy, or other clinical assessment as determined by prescriber.
- Serious bleeding episodes include bleeds in the following sites: intracranial; neck/throat; gastrointestinal; joints (hemarthrosis); muscles (especially deep compartments such as the iliopsoas, calf, forearm); or mucous membranes of the mouth, nose, and genitourinary tract.
- A spontaneous bleed is defined as a bleeding episode that occurs without apparent cause and is not the result of trauma.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Hemophilia A or B without inhibitors	One loading dose of 300 mg SC, followed by a maintenance dose of 150 mg SC once weekly on the same day each week, at any time of day. Consider a dose adjustment to 300 mg SC injection weekly in patients weighing ≥ 50 kg when control of bleeding events is judged to be inadequate by the healthcare provider.	300 mg/week

VI. Product Availability
- Single-dose prefilled pen: 150 mg/mL
- Single-dose prefilled syringe: 150 mg/mL

VII. References

1. Hympavzi Prescribing Information. New York, NY: Pfizer; October 2024. Available at: https://labeling.pfizer.com/ShowLabeling.aspx?id=20916. Accessed October 18, 2024.
2. ClinicalTrials.gov. Study of the efficacy and safety PF-06741086 in adult and teenage participants with severe hemophilia A or moderately severe to severe hemophilia B. Available at: https://clinicaltrials.gov/study/NCT03938792. Accessed October 18, 2024.
3. Efficacy and safety of the anti-tissue factor pathway inhibitor marstacimab in participants with severe hemophilia without inhibitors: results from the phase 3 Basis trial. December 9, 2023. Abstract #285 - Oral and Poster Abstracts: American Society of Hematology (ASH) Annual Meeting 2023. Available at: https://ash.confex.com/ash/2023/webprogram/Paper181263.html. Accessed January 20, 2024.
4. Srivastava A, Santagostino E, Dougall A, et al. WFH guidelines for the management of hemophilia. Haemophilia. 2020;26(suppl 6):1-158.
5. Medical and Scientific Advisory Council (MASAC) of the National Bleeding Disorders Foundation (formerly National Hemophilia Foundation): Database of treatment guidelines. Available at https://www.hemophilia.org/healthcare-professionals/guidelines-on-care/masac-documents. Accessed October 22, 2024.
6. Rezende SM, Neumann I, Angchaisuksiri P, et al. International Society on Thrombosis and Haemostasis clinical practice guideline for treatment of congenital hemophilia A and B based on the Grading of Recommendations Assessment, Development, and Evaluation methodology. *J Thromb Haemost*. 2024;22(9):2629-2652.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J7172	Injection, marstacimab-hncq, 0.5 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created pre-emptively	02.13.24	05.24
Drug is now FDA approved – criteria updated per FDA labeling: removed requirement for weight ≥ 35 kg; clarified hemophilia B from "moderate" to "moderately severe"; added option of at least one serious spontaneous bleed to the classification criteria of hemophilia A and B; removed option for ≥ 6 acute bleeding episodes in the previous 6 months; added redirection to Hemlibra for hemophilia A per SDC recommendation; added standard adverse effect or contraindication template language to failure of a FVIII or FIX product criterion; for continued therapy, added maximum maintenance dosing option of 300 mg weekly for	10.24.24	02.25

Reviews, Revisions, and Approvals	Date	P&T Approval Date
patients weighing ≥ 50 kg when control of bleeding events is judged to be inadequate by the provider; added Commercial approval duration of 6 months or to the member's renewal date, whichever is longer to both initial and continued therapy criteria; revised continued approval duration for Medicaid & HIM to 12 months; references reviewed and updated.		
HCPCS code added [C9304], removed codes [C9399, J3590].	04.02.25	
HCPCS code added [J7172] replacing code [C9304].	05.16.25	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to

recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.