Clinical Policy: Caplacizumab-yhdp (Cablivi)

Reference Number: CP.PHAR.416
Effective Date: 03.12.19
Last Review Date: 05.26
Line of Business: Commercial, HIM/ICHRA, Medicaid

Coding Implications
Revision Log

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

Description

Caplacizumab-yhdp (Cablivi®) is a von Willebrand factor (vWF)-directed antibody fragment.

FDA Approved Indication(s)

Cablivi is indicated for the treatment of adult and pediatric patients 12 years of age and older with acquired thrombotic thrombocytopenic purpura (aTTP), in combination with plasma exchange and immunosuppressive therapy.

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 Cablivi is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Acquired Thrombotic Thrombocytopenic Purpura (must meet all)**:**

1. Diagnosis of aTTP confirmed by one of the following (a or b):
   a. ADAMTS13 activity < 10% of normal;
   b. PLASMIC score of 6 to 7 (*see Appendix D*);
2. Prescribed by or in consultation with a hematologist;
3. Age ≥ 12 years;
4. Prescribed in combination with plasma exchange therapy;
5. Prescribed in combination with immunosuppressive therapy (i.e., glucocorticoids, rituximab);
   **Prior authorization may be required for rituximab*
6. Dose does not exceed (a and b) (*see Section V)*:
   a. Loading dose on Day 1: 11 mg pre-plasma exchange and 11 mg post-plasma exchange (22 mg total);
   b. Maintenance: 11 mg per day.

Approval duration: 30 days

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/ICHRA) 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/ICHRA, and CP.PMN.255 for Medicaid; or

b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) 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/ICHRA, 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/ICHRA, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Acquired Thrombotic Thrombocytopenic Purpura (must meet all)**:**

1. Previously received medication for the covered indication or member has previously met initial approval criteria;
2. Member meets one of the following (a or b):
   a. If request is for a new treatment cycle, all of the following (i, ii, and iii):
      i. Member has experienced no more than two recurrences (*see Appendix D*) while taking Cablivi;
      ii. Cablivi is prescribed in combination with plasma exchange and immunosuppressive therapy (i.e., glucocorticoids, rituximab);
      iii. aTTP has relapsed as evidenced by one of the following (1 or 2):
         1) ADAMTS13 activity < 10% of normal;
         2) PLASMIC score of 6 to 7 (*see Appendix D*);
   b. If request is for treatment extension, all of the following (i, ii, and iii):
      i. Member is responding positively to therapy as evidenced by, including but not limited to, improvement in any of the following parameters: increase in platelet counts, reduction in neurological symptoms, or improvements in organ-damage markers (lactate dehydrogenase, cardiac troponin I, and serum creatinine);
      ii. Member continues to have signs of persistent underlying disease (e.g., suppressed ADAMTS13 activity levels remain present);
      iii. Member has received no more than 58 days of Cablivi therapy after completion of plasma exchange therapy;
3. Dose does not exceed the following:
   a. For new treatment cycle: loading dose of 22 mg on day 1, followed by maintenance dose of 11 mg per day;
   b. For treatment extension: 11 mg per day.

Approval duration:
New treatment cycle – 30 days
Treatment extension – Up to a total duration of 58 days post plasma-exchange

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/ICHRA) 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/ICHRA, and CP.PMN.255 for Medicaid; or
b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) 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/ICHRA, 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/ICHRA, 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/ICHRA, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

aTTP: acquired thrombotic thrombocytopenic purpura
FDA: Food and Drug Administration
PEX: plasma exchange
vWF: von Willebrand factor

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	Dose Limit/ Maximum Dose
Plasma exchange (PEX) • Fresh frozen plasma • Solvent detergent/ viral-inactivated plasma • Cryosupernatant	1 to 1.5x estimated plasma volume daily until two days after normalization of platelet count (≥ 150 x 10^9/L)	1 to 1.5x estimated plasma volume
methylprednisone (Solu-Medrol®)	1mg/kg/day IV or PO during PEX and continued for 1 week after PEX. Tapered with the goal of being corticosteroid-free by day 30 after PEX	1 mg/kg/day
Rituxan®, Riabni™, Ruxience®, Truxima® (rituximab / biosimilars [-arrx, -pvvr, -abbs])	375mg/m^2 IV once weekly for 4 weeks or a reduced dose of 200 mg once weekly for 4 weeks administered immediately after PEX[4]	375 mg/m^2 once weekly

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): previous severe hypersensitivity reaction to caplacizumab-yhdp or any of the excipients
- Boxed warning(s): none reported

Appendix D: General Information

- The prescribing information for Cablivi states that Cablivi should be discontinued if the patient experiences more than 2 recurrences of aTTP while on Cablivi.
- Recurrence is defined as a new decrease (while receiving Cablivi) in the platelet count during the 30-day post daily PEX period that necessitates reinitiation of PEX after normalization of platelet count (≥ 150,000/microL) has occurred.
- Refractory disease is TTP that does not respond to initial treatment with PEX and glucocorticoids (e.g., lack of doubling of the platelet count within four days of initiation, occurrence of new neurologic symptoms not attributable to bleeding or infection).
- A plasma ADAMTS13 activity of < 10 IU/dL (often referred to as 10% of normal ADAMTS13 activity) is the hallmark of TTP. PLASMIC score can be used to estimate the likelihood of severe ADAMTS13 deficiency (< 10%) in adults with suspected TTP (1 point for each) and includes the following parameters:[5]
  - Platelet count < 30,000/microL
  - One or more indicators of hemolysis: reticulocyte count > 2.5%, haptoglobin undetectable, or indirect bilirubin > 2.0 mg/dL [> 34 mcmol/L]
  - No active cancer in the preceding year
  - No history of solid organ or hematopoietic stem cell transplant
  - Mean corpuscular volume (MCV) < 90 femtoliters
  - International normalized ratio (INR) < 1.5
  - Creatinine < 2.0 mg/dL [< 177 mcmol/L]

PLASMIC score (points)	Risk of severe ADAMTS13 deficiency (< 10%)
0 to 4	Low risk (0-4%)
5	Intermediate risk (5-24%)
6 to 7	High risk (62-82%)

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
aTTP	First day of treatment: 11 mg bolus intravenous injection at least 15 minutes prior to plasma exchange followed by an 11 mg subcutaneous injection after completion of plasma exchange on day 1. Subsequent days of treatment during daily plasma exchange: 11 mg subcutaneous injection once daily following plasma exchange. Treatment after plasma exchange period: 11 mg subcutaneous injection once daily continuing for 30 days following the last daily plasma exchange. If after initial treatment course, sign(s) of persistent underlying disease such as suppressed ADAMTS13 activity levels remain	Loading: 22 mg/day Maintenance: 11 mg/day

Indication	Dosing Regimen	Maximum Dose
	present, treatment may be extended for a maximum of 28 days.	

VI. Product Availability

Lyophilized power in a single-dose vial for injection: 11 mg

VII. References

1. Cablivi Prescribing Information. Ghent, Belgium: Ablynx N.V., Inc.; December 2025. Available at: http://products.sanofi.us/cablivi/cablivi.pdf. Accessed January 22, 2026.
2. Scully M, Cataland SR, Peyvandi F, et al. Caplacizumab treatment for acquired thrombotic thrombocytopenic purpura. N Engl J Med. 2019 Jan 24:380(4):335-346.
3. Scully M, Rayment R, Clark A, et al; BSH Committee. A British Society for Haematology guideline: Diagnosis and management of thrombotic thrombocytopenic purpura and thrombotic microangiopathies. British Journal of Haematology. 2023 Nov; 203(4): 546-563. doi: 10.1111/bjh.19026.
4. Zheng XL, Vesely SK, Cataland SR, et al. ISTH guidelines for the diagnosis and treatment of thrombotic thrombocytopenic purpura. J Thromb Haemost. 2020 July;18(10):2486-2502.
5. Zheng XL, Al-Housni Z, Cataland SR, et al. 2025 focused update of the 2020 ISTH guidelines for management of thrombotic thrombocytopenic purpura. J Thromb Haemost. 2025;23(11):3711-3732.
6. Page EE, Kremer-Hovinga JA, Terrell DR, et al. Rituximab reduces risk for relapse in patients with thrombotic thrombocytopenic purpura. Blood. 2016;127(24):3092
7. Bendapudi PK, Hurwitz S, Fry A, et al. Derivation and external validation of the PLASMIC score for rapid assessment of adults with thrombotic microangiopathies: a cohort study. Lancet Haematology. 2017;4(4):e157.
8. Scully M, de la Rubia J, Pavenski K, et al. Abstract 2080: Long-term safety and efficacy of caplacizumab for acquired thrombotic thrombocytopenic purpura (aTTP): The post-HERCULES study. Presented at 2021 ASH Annual Meeting on December 12, 2021.

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
C9047	Injection, caplacizumab-yhdp, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2022 annual review: for treatment extension requests, added requirement that member continues to have signs of persistent underlying disease per PI; clarified that requirement for maximum 58 days of therapy per treatment cycle applies to treatment extension requests; added Coding Implications section; references reviewed and updated.	01.27.22	05.22

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Added alternate pathway for confirmation of diagnosis with ADAMTS13 level with additional information in Appendix D.	05.26.22	08.22
Template changes applied to other diagnoses/indications.	09.23.22	
2Q 2023 annual review: no significant changes; references reviewed and updated.	01.23.23	05.23
2Q 2024 annual review: no significant changes; references reviewed and updated.	02.08.24	05.24
2Q 2025 annual review: no significant changes; references reviewed and updated.	02.03.25	05.25
RT4: updated with pediatric age extension of ≥ 12 years.	01.16.26	
2Q 2026 annual review: for continued criteria for new treatment cycle requests, added diagnostic requirement for confirmation of relapse; references reviewed and updated. Added ICHRA line of business.	03.30.26	05.26

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.