Preemptive policy: This is a P&T approved policy and can be used after the drug is FDA approved until it is superseded by an updated policy

CENTENE® Corporation

Clinical Policy: Efzimfotase Alfa (ALXN1850)

Reference Number: CP.PHAR.816
Effective Date: FDA Approval Date
Last Review Date: 11.26
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.

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Description

Efzimfotase alfa (ALXN1850®/™) is a tissue-nonspecific alkaline phosphatase.

FDA Approved Indication(s)

ALXN1850 is indicated for the treatment of patients with hypophosphatasia (HPP).

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 ALXN1850 is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria*

**Criteria will mirror the clinical information from the prescribing information once FDA-approved*

A. Hypophosphatasia (must meet all)**:**

1. Diagnosis of perinatal/infantile- or juvenile-onset HPP as evidenced by all of the following (a, b, and c):*
   a. Age of onset is < 18 years;
   b. Presence of one of the following laboratory indices (i, ii, or iii):
      i. Molecular genetic testing documenting tissue non-specific alkaline phosphatase (ALPL) gene mutation;
      ii. Low baseline serum alkaline phosphatase activity;
      iii. An elevated level of a tissue non-specific alkaline phosphatase substrate (i.e., serum pyridoxal 5'-phosphate, serum or urinary inorganic pyrophosphate, urinary phosphoethanolamine);
   c. History of one of the following HPP clinical manifestations (i, ii, iii, or iv):
      i. Vitamin B6-dependent seizures;
      ii. Failure to thrive or growth failure/short stature;
      iii. Nephrocalcinosis with hypercalcemia/hypercalciuria;
      iv. Skeletal abnormalities and associated impairments (any of the following):
         a) Craniosynostosis (premature fusion of one or more cranial sutures) with increased intracranial pressure;
         b) Rachitic chest deformity (costochondral junction enlargement seen in advanced rickets) with associated respiratory compromise;

c) Limb deformity with delayed walking or gait abnormality;
d) Compromised exercise capacity due to rickets and muscle weakness;
e) Low bone mineral density for age with unexplained fractures;
f) Alveolar bone loss with premature loss of deciduous (primary) teeth;

2. Prescribed by or in consultation with an endocrinologist;
3. Age ≥ 2 years;*
4. ALXN1850 is not prescribed concurrently with Strensiq®;
5. Dose does not exceed the FDA-approved maximum dose.

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to 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/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*

**Criteria will mirror the clinical information from the prescribing information once FDA-approved*

A. Hypophosphatasia (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, as evidenced by improvement in any of the following on initial re-authorization request:*
   a. Height velocity;
   b. Respiratory function;
   c. Skeletal manifestations (e.g., bone mineralization, bone formation and remodeling, fractures, deformities);
   d. Motor function, mobility, or gait;

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3. ALXN1850 is not prescribed concurrently with Strensiq;
4. If request is for a dose increase, new dose does not exceed the FDA-labeled maximum dose.*

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to 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/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
FDA: Food and Drug Administration
HPP: hypophosphatasia

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings [Pending]
- Contraindication(s): pending
- Boxed warning(s): pending

Appendix D: General Information
HICKORY is one of three pivotal trials evaluating ALXN1850 in adolescents aged 12 to < 18 years and adults with HPP. In HICKORY, ALXN1850 produced numerical improvement

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in Six-Minute Walk Test (6MWT) performance but did not meet statistical significance for this primary endpoint. Given the lack of current established evidence in the adult-onset HPP population, criteria reflect HPP age of onset < 18 years.

V. Dosage and Administration [Pending]

Indication	Dosing Regimen	Maximum Dose
HPP	SC every 2 weeks*	50 mg/2 weeks*

VI. Product Availability [Pending]

Pending

VII. References

1. ClinicalTrials.gov. Phase 3 study of ALXN1850 in treatment-naïve pediatric participants with HPP (MULBERRY). Updated May 28, 2026. Available at: https://clinicaltrials.gov/study/NCT06079359. Accessed October 13, 2026.
2. ClinicalTrials.gov. Phase 3 study of ALXN1850 in pediatric participants with HPP previously treated with asfotase alfa (CHESTNUT). Updated May 5, 2026. Available at: https://clinicaltrials.gov/study/NCT06079372. Accessed October 13, 2026.
3. ClinicalTrials.gov. Phase 3 study of ALXN1850 versus placebo in adolescent and adult participants with HPP who have not previously been treated with asfotase alfa (HICKORY). Updated June 22, 2026. Available at: https://clinicaltrials.gov/study/NCT06079281. Accessed October 13, 2026.
4. Khan AA, Brandi ML, Rush ET, et al. Hypophosphatasia diagnosis: current state of the art and proposed diagnostic criteria for children and adults. Osteoporosis International. 2024;35:431-8. https://doi.org/10.1007/s00198-023-06844-1.
5. Cardenas-Aguilera JG, Gonzalez-Lopez V, Zarante-Bahamon AM, et al. Diagnosis, treatment, and follow-up of patients with hypophosphatasia. Endocrine. 2025;87:400-19. https://doi.org/10.1007/s12020-024-04054-1.
6. Seefried L, Genest F, Hofmann C, et al. Diagnosis and treatment of hypophosphatasia. Calcified Tissue Intl. 2026;116:46. https://doi.org/10.1007/s00223-025-01356-y.

Coding Implications [Pending]

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
Pending	Pending

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created pre-emptively.	10.13.26	11.26

IN THIS POLICY AND INFORMATION IS SUBJECT TO CHANGE

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.

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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.

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