AETNA BETTER HEALTH®

Non-Formulary Prior Authorization guideline for Hemophilia Factor Replacement

Hemophilia Factor Replacement Therapy:
  • Factor VIIa: Novoseven RT
  • Factor IX: Alphanine SD, Mononine, Bebulin VH, Proplex T, Profilnine SD, Benefix

Authorization guidelines
For Members in the following diagnostic categories who meet the following criteria:
  1. Treatment of hemorrhagic complications in patients with hemophilia A, hemophilia B or von Willebrand’s disease,
     OR
  2. Prevention of bleeding in surgical or invasive procedures in patients with hemophilia A, hemophilia B or von Willebrand’s disease
     OR
  3. Primary prophylactic therapy for patients with severe hemophilia A or hemophilia B (less than 1% of normal factor (less than 0.01 IU/ml));
     OR
  4. Secondary prophylactic therapy for patients with hemophilia A or hemophilia B (regardless of normal factor levels) and has documented history of two or more episodes of spontaneous bleeding into joints.

DISCONTINUATION OF COVERAGE:
Hemophilia factor replacement therapy will NOT be covered if any of the following discontinuation criteria is met:
  1. Development of an inhibitor (lack of response to factor VIII or IX); OR
  2. Documentation of contraindication to the use of hemophilia factor; OR

Authorization and Limitations
Initial Approval: 3 months
Extended Approval: Annual Review
PROCUREMENT
Specialty pharmacy source: CVS Specialty Pharmacy
Contact:
CVS Specialty Pharmacy toll free number: 1-866-638-1232
CVS Specialty Pharmacy fax number: 1-866-207-7231

Additional Information:
Hemophilia Factor Replacement Therapy is NOT covered for members with the following criteria:

- Use not approved by the FDA; AND
- The use is unapproved and not supported by the literature or evidence as an accepted off-label use.

Medically Necessary — A service or benefit is Medically Necessary if it is compensable under the MA Program and if it meets any one of the following standards:

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or exception basis, must be documented in writing.

The determination is based on medical information provided by the Member, the Member’s family/caretaker and the Primary Care Practitioner, as well as any other Providers, programs, agencies that have evaluated the Member.

All such determinations must be made by qualified and trained Health Care Providers. A Health Care Provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under this Agreement.

References:


