



MEDICAL COVERAGE POLICY

SERVICE: Hemophilia A Medications

Policy Number:	288
Effective Date:	04/01/2021
Last Review:	02/25/2021
Next Review Date:	02/25/2022

Important note:

Unless otherwise indicated, this policy will apply to all lines of business.

Even though this policy may indicate that a particular service or supply may be considered medically necessary and thus covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage (EOC) or Summary Plan Description (SPD) to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Medicare-linked plan members, this policy will apply unless there are Medicare policies that provide differing coverage rules, in which case Medicare coverage rules supersede guidelines in this policy. Medicare-linked plan policies will only apply to benefits paid for under Medicare rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the CMS website. Similarly, for Medicaid-linked plans, the Texas Medicaid Provider Procedures Manual (TMPPM) supersedes coverage guidelines in this policy where applicable.

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PRIOR AUTHORIZATION: **Varies by plan**

POLICY: SWHP/FirstCare covers the following medications with no preferences within this class:

1. Advate (Factor VIII recombinant)
2. Adynovate (antihemophilic factor VIII recombinant pegylated)
3. Afstyla (Antihemophilic factor VIII recomb, single-CHN, B-DOM truncated)
4. Alphanate (Antihemophilic Factor, Human/Von Willebrand Factor, Human)
5. Eloctate (antihemophilic factor recombinant, Fc fusion protein)
6. Helixate FS (Factor VIII recombinant)
7. Hemofil-M (antihemophilic factor, human)
8. Humate-P (Antihemophilic Factor, Human/Von Willebrand Factor, Human)
9. Jivi (antihemophilic factor (recombinant), PEGylated-aucl)
10. Koate-DVI (antihemophilic factor, human)
11. Kogenate (Factor VIII recombinant)
12. Kogenate FS (Factor VIII recombinant)
13. Kovaltry (Antihemophilic factor (FVIII) recombinant, full length)
14. Monoclote-P (antihemophilic factor, human)
15. Novoeight (antihemophilic factor, recombinant)
16. Nuwiq (antihemophilic factor VIII recombinant)
17. Recombinate (Factor VIII recombinant)
18. Xyntha (coagulation factor VIII recombinant)

Please refer to medical coverage policy #215 Medications Covered Under Medical Insurance Policy for clinical criteria for coverage. For medications with a non-preferred status, member must meet one of the following criteria with preferred drug(s) in the same class: a) failure of an adequate trial b) clinically significant intolerance c) contraindication.



Scott & White
HEALTH PLAN
 PART OF BAYLOR SCOTT & WHITE HEALTH



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CODES:

Important note:

CODES: Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.

CPT Codes:	
CPT Not Covered:	
HCPCS Codes:	J7182, J7185, J7186, J7187, J7190, J7192, J7205, J7207, J7208, J7209, J7210, J7211
ICD10 codes:	
ICD10 Not covered:	

CMS:

POLICY HISTORY:

Status	Date	Action
New	2/25/2021	New policy