Clinical Policy: Factor VIIa, Recombinant (NovoSeven RT, SevenFact)

Reference Number: CP.PHAR.220
Effective Date: 05.01.16
Last Review Date: 02.21 Coding Implications
Line of Business: Commercial, HIM, Medicaid Revision Log

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

Description

Factor VIIa, recombinant (NovoSeven® RT) and coagulation factor VIIa (recombinant)-jncw (SevenFact®) are coagulation factors.

FDA Approved Indication(s)

NovoSeven RT is indicated for treatment of bleeding episodes and perioperative management in:

- Adults and children with hemophilia A or B with inhibitors, congenital factor VII (FVII) deficiency, and Glanzmann's thrombasthenia with refractoriness to platelet transfusions, with or without antibodies to platelets
- Adults with acquired hemophilia

SevenFact is indicated for the treatment and control of bleeding episodes occurring in adults and adolescents (12 years of age and older) with hemophilia A or B with inhibitors.

Limitation(s) of Use: SevenFact is not indicated for treatment of congenital factor VII deficiency.

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 NovoSeven RT and SevenFact are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Hemophilia A or B with Inhibitors, Congenital Factor VII Deficiency (must meet all)**:**

1. Diagnosis of one of the following (a or b):
   a. Congenital or acquired hemophilia A or B with inhibitors;
   b. Congenital factor VII deficiency (NovoSeven RT requests only);
2. Prescribed by or in consultation with a hematologist;
3. For SevenFact requests only: Age ≥ 12 years;
4. Request is for one of the following uses (a or b):
   a. Control and prevention of bleeding episodes;
   b. Perioperative management (NovoSeven RT requests only);
5. Documentation of member's current body weight (in kg);
6. Dose does not exceed one of the following (a or b):

a. For NovoSeven requests:
   i. Hemophilia: 90 mcg/kg every two hours;
   ii. Congenital factor VII deficiency: 30 mcg/kg every four hours;
b. For SevenFact requests: 75 mcg/kg every 2 hours.

Approval duration: 3 months

B. Glanzmann's Thrombasthenia (must meet all)**:**
1. Diagnosis of Glanzmann's thrombasthenia (NovoSeven RT requests only);
2. Prescribed by or in consultation with a hematologist;
3. Condition is refractory to platelet transfusions;
4. Documentation of member's current body weight (in kg);
5. Request is for one of the following uses (a or b):
   a. Control and prevention of bleeding episodes;
   b. Perioperative management;
6. Dose does not exceed 90 mcg/kg every two hours.

Approval duration: 3 months

C. Other diagnoses/indications
1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**
1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. Documentation of member's current body weight (in kg);
4. If request is for a dose increase, new dose does not exceed one of the following (a or b):
   a. For NovoSeven requests:
      i. Hemophilia: 90 mcg/kg every two hours;
      ii. Congenital factor VII deficiency: 30 mcg/kg every four hours;
   b. For SevenFact requests: 75 mcg/kg every 2 hours.

Approval duration: 3 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 3 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): 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 policy – 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

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
  - NovoSeven RT: none reported
  - SevenFact: known allergy to rabbits or rabbit proteins; severe hypersensitivity reaction to SevenFact or any of its components
- Boxed warning(s): thrombosis

Appendix D: General Information

- Congenital hemophilia A is a deficiency of factor VIII.
- Congenital hemophilia B is a deficiency of factor IX.
- Acquired hemophilia is evidenced by presence of coagulation factor inhibitors (autoantibodies).

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Factor VIIa, recombinant (NovoSeven RT)	Treatment of bleeding episodes	<u>Congenital hemophilia A or B with inhibitors:</u> • 90 mcg/kg IV every 2 hrs, adjustable based on severity of bleeding until hemostasis is achieved • 90 mcg/kg IV every 3-6 hrs after hemostasis is achieved for severe bleeds <u>Congenital factor VII deficiency:</u> 15-30 mcg/kg IV every 4-6 hrs until hemostasis is achieved <u>Glanzmann's thrombasthenia</u>:	Congenital factor VII deficiency: 30 mcg/kg every 4 hrs All other indications: 90 mcg/kg every 2 hrs

Drug Name	Indication	Dosing Regimen	Maximum Dose
		90 mcg/kg IV every 2-6 hrs until hemostasis is achieved <u>Acquired hemophilia</u>: 70-90 mcg/kg IV every 2-3 hrs until hemostasis is achieved	
Factor VIIa, recombinant (NovoSeven RT)	Peri-operative management	<u>Congenital hemophilia A or B with inhibitors:</u> *Minor surgery:* • 90 mcg/kg IV immediately before surgery, repeat every 2 hrs during surgery • 90 mcg/kg IV every 2 hrs after surgery for 48 hours, then every 2-6 hrs until healing has occurred *Major surgery:* • 90 mcg/kg IV immediately before surgery, repeat every 2 hrs during surgery • 90 mcg/kg IV every 2 hrs after surgery for 5 days, then every 4 hrs or by continuous infusion at 50 mcg/kg/hr until healing has occurred • Additional boluses can be given <u>Congenital factor VII deficiency:</u> 15-30 mcg/kg IV immediately before surgery and every 4-6 hours for the duration of surgery and until hemostasis is achieved Note: doses as low as 10 mcg/kg can be effective <u>Glanzmann's thrombasthenia:</u> • 90 mcg/kg IV immediately before surgery and repeat every 2 hrs for the duration of the procedure • 90 mcg/kg IV every 2-6 hrs to prevent post-operative bleeding	Congenital factor VII deficiency: 30 mcg/kg every 4 hrs Glanzmann's thrombasthenia: 140 mcg/kg every 2 hrs All other indications: 90 mcg/kg every 2 hrs

Drug Name	Indication	Dosing Regimen	Maximum Dose
		• Higher doses of 100-140 mcg/kg can be used for surgical patients who have clinical refractoriness with or without platelet-specific antibodies Acquired hemophilia: 70-90 mcg/kg immediately before surgery and every 2-3 hrs for the duration of surgery and until hemostasis is achieved	
Coagulation factor VIIa (recombinant)-jncw (SevenFact)	Treatment and control of bleeding episodes	For mild or moderate bleeds: 75 mcg/kg IV every 3 hrs until hemostasis is achieved OR Initial dose of 225 mcg/kg; if hemostasis is not achieved within 9 hrs, additional 75 mcg/kg every 3 hrs as needed to achieve hemostasis For severe bleeds: 225 mcg/kg, followed if necessary 6 hrs later with 75 mcg/kg every 2 hrs	75 mcg/kg every 3 hrs

VI. Product Availability

Drug Name	Availability
Factor VIIa, recombinant (NovoSeven RT)	Powder for reconstitution in single-use vial: 1 mg, 2 mg, 5 mg, 8 mg
Coagulation factor VIIa (recombinant)-jncw (SevenFact)	Lyophilized powder for reconstitution in single-use vial: 1 mg, 5 mg

VII. References

1. NovoSeven RT Prescribing Information. Plainsboro, NJ: Novo Nordisk, Inc.; July 2020. Available at http://www.novosevenrt.com. Accessed December 1, 2020.
2. SevenFact Prescribing Information. Louisville, KY: HEMA Biologics; April 2020. Available at: https://www.fda.gov/vaccines-blood-biologics/sevenfact. Accessed December 1, 2020.
3. Srivastava A, Brewer AK, Mauser-Bunschoten EP, et al. Guidelines for the management of hemophilia. Haemophilia. Jan 2013; 19(1): e1-47.
4. Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation (NHF): Database of treatment guidelines. Available at

https://www.hemophilia.org/Researchers-Healthcare-Providers/Medical-and-Scientific-Advisory-Council-MASAC/MASAC-Recommendations. Accessed December 1, 2020.

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
J7189	Factor VIIa (antihemophilic factor, recombinant), per 1 mcg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Safety information removed. Wording for uses and approval periods for all blood factor products made consistent across all policies. Efficacy statement added to renewal criteria. Hemophilias are specified as "congenital" versus "acquired" across blood factor policies where indicated. Added requirement that acquired hemophilia be evidenced by the presence of factor VIII inhibitors. Reviewed by specialist- hematology/internal medicine.	04.01.17	05.17
1Q18 annual review: - No significant changes - Converted to new template - References reviewed and updated.	11.29.17	02.18
1Q 2019 annual review: added HIM-Medical Benefit; no significant changes; references reviewed and updated.	09.26.18	02.19
1Q 2020 annual review: no significant changes; added HIM line of business; references reviewed and updated.	11.27.19	02.20
RT4: Added newly approved product SevenFact to the policy.	04.21.20	
1Q 2021 annual review: added commercial line of business; added requirement for documentation of member's body weight for calculation of appropriate dosage; clarified covered indications for SevenFact to align with FDA label; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	12.01.20	02.21

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.