

## Factor X Prior Authorization

Drug Applied:	Coagadex
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### Criteria:

Drug(s) Applied will be approved when the requested medication is being used for an FDA approved indication and all of the following criteria are met:

#### I. Initial Approval Criteria

##### A. Hereditary Factor X Deficiency as indicated by chart notes within past 90 days

1. Requested agent is being used for ONE of the following:
  - a) Patient is currently experiencing a bleed and is out of medication and needs to receive a ONE TIME emergency supply of medication **or**
  - b) Prophylaxis treatment **or**
  - c) On-demand treatment to control bleeding episodes, prescriber has verified that the patient does NOT have more than 5 on-demand doses on hand **or**
  - d) Perioperative management of bleeding, patient has mild (Factor X level 6-10%), moderate (Factor X level 1-5%), or severe (< 1%) hereditary Factor X deficiency **and**
2. There is NO documentation indicating the patient will be using the requested agent in combination with an indirect or direct Factor Xa inhibitor [e.g., apixaban (Eliquis), dalteparin (Fragmin), edoxaban (Savaysa), enoxaparin (Lovenox), fondaparinux (Arixtra), rivaroxaban (Xarelto) or warfarin (Coumadin)] **and**
3. Prescriber is a specialist or has consulted with a specialist in the area of the patient's diagnosis (e.g., hematology)

##### Approval Duration:

**One time emergency use OR perioperative management of bleeding:** 1 time

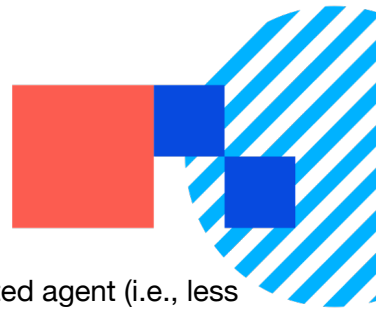
**On-demand treatment:** 3 months

**Prophylaxis treatment:** 12 months

#### II. Continued Therapy Approval

##### A. Hereditary Factor X Deficiency as indicated by chart notes within past 12 months

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization process (if current request is for a ONE TIME emergency use or the patient ONLY has previous approval(s) for emergency use, must use Initial Evaluation) or meets the initial therapy criteria above **and**
2. Patient has been treated with the requested agent (starting on samples is not approvable) within the past 90 days **and**



3. Patient has shown clinical benefit since starting the requested agent (i.e., less breakthrough bleeds) **and**
4. Prescriber is a specialist or has consulted with a specialist in the area of the patient's diagnosis (e.g., hematology)

**Approval Duration:** 12 months

**Policy Owned by:** Curative PBM team