curative

Factor IX Prior Authorization

Drug(s) Applied:	**AlphaNine SD** (factor IX) **Alprolix** (factor IX recombinant, Fc fusion protein) **BeneFIX** (factor IX human recombinant) **Idelvion** (factor IX recombinant, albumin fusion protein) **Profilnine** (factor IX complex, prothrombin complex concentrate no.4, 3-factor)

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. **Hemophilia B (also known as Factor IX deficiency, Christmas disease) without inhibitors** as indicated by chart notes within past 90 days
  1. ONE of the following:
     a) Patient is currently experiencing a bleed AND BOTH of the following:
        (1) Patient is out of medication **and**
        (2) Patient needs to receive a ONE TIME emergency supply of medication **or**
     b) Requested agent is being used for ONE of the following:
        (1) On-demand use for bleeds **or**
        (2) Peri-operative management of bleeding **or**
        (3) Prophylaxis **and**
  2. There is NO documentation indicating the patient will be using the requested agent in combination with another Factor IX agent **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: 12 months

II. Continued Therapy Approval
- A. **Hemophilia B (also known as Factor IX deficiency, Christmas disease) without inhibitors** 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 **and**
  2. Requested agent is being used for ONE of the following:
     a) On-demand use for bleeds **or**
     b) Peri-operative management of bleeding **or**

c) Prophylaxis **and**

3. There is NO documentation indicating the patient will be using the requested agent in combination with another Factor IX agent **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