



## Factor XIII Prior Authorization

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| Drug(s) Applied: | Corifact, Tretten |
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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. **Factor XIII deficiency (Congenital or A-Subunit deficiency)** as indicated by chart notes within past 90 days

1. 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**

2. 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. **Factor XIII deficiency (Congenital or A-Subunit 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 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