



Factor IX Prior Authorization Drug List A

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)
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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 Therapy 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)

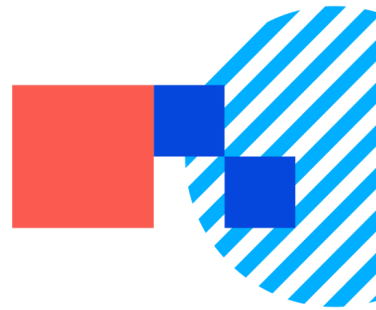
Approval Duration: 12 months

II. Continued Therapy Criteria

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