Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines
Medical Benefit Drug

Hemgenix® (etranacogene dezaparvovec-drlb)

Effective: January 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	Yes ☒ No ☐

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; Fax 617-673-0988
☒ Tufts Health Plan Commercial products; Fax 617-673-0988

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax 617-673-0988
☐ Tufts Health Together – MassHealth Accountable Care Partnership Plans; Fax 617-673-0939
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax 617-673-0939
☐ Tufts Health One Care -- A dual-eligible product; Fax 617-673-0956

Senior Products

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); Fax 617-673-0956
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); Fax 617-673-0956
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); Fax 617-673-0956

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Hemophilia B is a rare genetic bleeding disorder resulting from missing or insufficient levels of blood clotting FIX, a protein needed to produce blood clots to stop bleeding. The cause of this is due to a mutation on the F9 gene. Symptoms can include prolonged or heavy bleeding after an injury, surgery, or dental procedure; in severe cases, bleeding episodes can occur spontaneously without a clear cause. Prolonged bleeding episodes can lead to serious complications, such as bleeding into joints, muscles, or internal organs, including the brain. Hemophilia B is classified as mild, moderate or severe based upon the activity level of factor IX.

- Individuals with mild hemophilia have factor IX levels between 5 and 40% of normal
- Those with moderate hemophilia have factor levels from 1 to 5% of normal
- Patients with severe hemophilia have factor levels less than 1% of normal

About 2/3 of Hemophilia B patients have a moderate or severe version of the condition. Diagnosis is usually at a younger age among patients with the severe (≤2 years) or moderate (<5-6 years) form of the disorder compared with those with mild disease who are typically diagnosed later in life or in adulthood.

Food and Drug Administration (FDA) Approved Indication(s):

Hemgenix (etranacogene dezaparvovec-drlb) is an adeno-associated virus vector-based gene therapy indicated for the treatment of adults with Hemophilia B (congenital Factor IX deficiency) who:

- Currently use Factor IX prophylaxis therapy, or
- Have a current or historical life-threatening hemorrhage, or
- Have repeated, serious spontaneous bleeding episodes

Hemgenix is an adeno-associated virus serotype 5 (AAV5) based gene therapy designed to deliver a copy of a gene encoding the

Padua variant of human coagulation Factor IX (hFIX-Padua). A single intravenous infusion of Hemgenix results in cell transduction and increase in circulating Factor IX activity in patients with Hemophilia B.

Prior to the approval of Hemgenix, standard-of-care treatment for patients with moderate to severe hemophilia included prophylaxis with FIX replacement therapy, self-administered intravenously multiple times a week.

Clinical Guideline Coverage Criteria

The Plan may cover Hemgenix when all of the following criteria is met:

1. The Member has been diagnosed with Congenital Hemophilia B with Factor IX (FIX) activity ≤2% of normal, classified as either:
    a. Severe (FIX <1%), *or*
    b. Moderately severe (FIX 1%-2%)

AND

2. The Member has received continuous FIX protein prophylaxis for ≥ 2 months

AND

3. The Member has had > 150 previous exposure days of treatment with FIX protein within their lifetime

AND

4. The Member is 18 years of age or older

AND

5. The Member does not have a history of FIX inhibitors or test positive for FIX inhibitors at screening (defined as greater than or equal to 0.6 Bethesda units)

AND

6. Prior to treatment, the Member does not have LFT values (ALT, AST, bilirubin, alkaline phosphatase [ALP], creatinine) greater than 2 times the upper limit of normal or evidence of advanced cirrhosis determined by hepatic ultrasound and elastography, unless a consulting hepatologist has assessed the Member as being eligible to undergo treatment with Hemgenix

AND

7. If the Member tests positive for HIV, they are being adequately controlled with antiviral therapy

AND

8. The Member does not have an active infection with Hepatitis B or C virus at screening, or If the Member has a history of exposure to Hepatitis B or C, they are adequately controlled with antiviral therapy prior to initiation of Hemgenix

AND

9. The Member has not have received prior treatment with any gene therapy for Hemophilia B or are being considered for subsequent treatment with any other gene therapy for Hemophilia B

AND

10. Hemgenix must be administered at a qualified treatment site trained by CSL Behring

Limitations

- If approval criteria are met, the health plan may authorize Hemgenix for one treatment only.
- The Plan will not cover Hemgenix for any conditions other than FDA-approved indications. All other uses are considered experimental or investigational.

Codes

The following code(s) require prior authorization:

Table 1: HCPCS Codes

HCPCS Codes	Description
J1411	Injection, etranacogene dezaparvovec-drlb, per therapeutic dose

References:

1. Hemgenix (etranacogene dezaparvovec-drlb) [package insert]. King of Prussia, PA: CSL Behring LLC; November 2022.
2. HEMGENIX etranacogene dezaparvovec-drlb Dossier. CSL Behring. December 2022.
3. Centers for Disease Control and Prevention (CDC). What is Hemophilia B. 2020;

https://www.cdc.gov/ncbddd/hemophilia/facts.html.
4. Centers for Disease Control and Prevention. Factor VIII and factor IX. Accessed December 12, 2022 at https://www.cdc.gov/ncbddd/hemophilia/communitycounts/data-reports/2022-03/table-2-factor.html/
5. World Federation of Hemophilia. Report on the Annual Global Survey 2020. October 2021; https://www1.wfh.org/publications/files/pdf-2045.pdf. Accessed April 5, 2022.
6. National Hemophilia Foundation (NHF). Hemophilia B. 2022; https://www.hemophilia.org/bleeding-disorders-a-z/types/hemophilia-b. Accessed March 24, 2022.
7. National Hemophilia Foundation (NHF). MASAC Recommendations Concerning Products. Licensed for the Treatment of Hemophilia and Other Bleeding Disorders (MASAC Document 263). Revised August 2020. https://www.hemophilia.org/healthcare-professionals/guidelines-oncare/masac-documents/masac-document-263-masac-recommendations-concerning-productslicensed-for-the-treatment-of-hemophilia-and-other-bleeding-disorders. Accessed March 24, 2022.
8. Hermans C. Haemophilia gene therapy: experiences and lessons from treated patients. Orphanet J Rare Dis. 2022;17(1):154.
9. Miesbach W, Leebeek FWG, Recht M, et al. Final analysis from pivotal Phase 3 HOPE-B gene therapy trial: stable steady-state efficacy and safety of etranacogene dezaparvovec in adults with severe or moderately severe hemophilia B. Poster presented at: American Thrombosis and Hemostasis Network (ATHN) Data Summit 2022, October 19-22, 2022.
10. ClinicalTrials.Gov website. HOPE-B: An open-label, single-dose, single arm, multi-center, multinational, phase 3 safety and efficacy trial of AMT-061 in severe or moderately severe hemophilia B patients (NCT03569891). Updated March 21, 2022. https://clinicaltrials.gov/ct2/show/NCT03569891. Accessed April 5, 2022.
11. National Hemophilia Foundation (NHF). MASAC Recommendations on Standardized Testing and Surveillance for Inhibitors in Patients with Hemophilia A and B (MASAC Document 236). Revised October 2015. https://www.hemophilia.org/sites/default/files/document/files/236.pdf. Accessed March 24, 2022.
12. Gene Therapy for Hemophilia B and An Update on Gene Therapy for Hemophilia A: Effectiveness and Value Final Evidence Report Posted December 22, 2022. Institute for Clinical and Economic Review (ICER), 2022.
13. New Drug Review: Hemgenix (etranacogene dezaparvovec). IPD Analytics. December 2022.
14. Etranacogene dezaparvovec for treating moderately severe or severe haemophilia B. National Institute for Health and Care Excellence (NICE). Technology appraisal guidance Reference number: TA989. Published: July 24, 2024
15. Pipe SW, et. al. Gene Therapy with Etranacogene Dezaparvovec for Hemophilia B. N Engl J Med. 2023 Feb 23;388(8):706-718. doi: 10.1056/NEJMoa2211644. PMID: 36812434.
16. von Drygalski A, et. al. Stable and durable factor IX levels in patients with hemophilia B over 3 years after etranacogene dezaparvovec gene therapy. Blood Adv. 2023 Oct 10;7(19):5671-5679. doi: 10.1182/bloodadvances.2022008886. PMID: 36490302; PMCID: PMC10539871.
17. Coppens M, et. al. Leebeek FWG; HOPE-B Investigators. Etranacogene dezaparvovec gene therapy for haemophilia B (HOPE-B): 24-month post-hoc efficacy and safety data from a single-arm, multicentre, phase 3 trial. Lancet Haematol. 2024 Apr;11(4):e265-e275. doi: 10.1016/S2352-3026(24)00006-1. Epub 2024 Mar 1. PMID: 38437857.

Approval And Revision History

January 18, 2023: Reviewed by the Medical Policy Approval Committee (MPAC)

Subsequent endorsement date(s) and changes made:

- November 16, 2023: Reviewed by MPAC, renewed without changes
- November 2023: Rebranded Unify to One Care effective January 1, 2024
- November 21, 2024: Reviewed by MPAC, renewed without changes, effective January 1, 2025
- November 19, 2025: Reviewed by MPAC for annual review, renewed without changes, references updated, effective January 1, 2026
- December 2025: Administrative updates effective January 1, 2026

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field,

FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.