Neighborhood Health Plan OF RHODE ISLAND™
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Hympavzi ® (marstacimab-hncq)
(Subcutaneous)

Effective Date: 05/01/2025
Reviewed Date: 02/10/2025, 07/21/2026
Pharmacy Scope: Medicaid
Medical Scope: Medicaid, Commercial, Medicare

I. Length of Authorization

Coverage will be provided for 6 months and may be renewed

II. Dosing Limits

A. Quantity Limit (max daily dose)

- Hympavzi 150mg/ml: 4 syringes/pens (4 ml) per 28 days
- Quantity limit exception for first fill of 5 ml per 28 days (0.179ml/day) to be provided to allow for initial loading dose of 300mg (2 ml), followed one week later by 150mg weekly
- Quantity limit exception for 300mg weekly (8 ml per 28 days or 0.286 ml per day) as maintenance dose may be provided with documentation of inadequate clinical response (i.e. control of bleeding events) at lower dose in patients weighing greater than or equal to 50 kg
- Max weekly dose is 300mg weekly

B. Max Units (per dose and over time) [HCPCS Unit]:

- 600 units every week

III. Summary of Evidence

Hympavzi (marstacimab-hncq) is indicated for routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adult and pediatric patients 6 years of age and older with hemophilia A with or without factor VIII inhibitors or hemophilia B with or without factor IX inhibitors (neutralizing antibodies). Hemophilia A and hemophilia B are genetic bleeding disorders caused by a dysfunction or deficiency of coagulation factor VIII (FVIII) or IX (FIX), respectively. Hympavzi's approval is based on the Phase 3 BASIS study which was an open-label, multi-center study in 116 adult and pediatric male patients with either severe hemophilia A or severe hemophilia B, both without inhibitors. For the first six months of this study, patients received treatment with replacement factor either on-demand (33 patients) or prophylactically (83 patients). These patients then received Hympavzi prophylaxis for 12 months. The primary measure of efficacy of Hympavzi was the annualized bleeding rates of treated bleeds. In the patients receiving on-demand factor replacement during the first six months of the study, the estimated annualized bleeding rate was 38 compared to the estimated annualized bleeding rate during treatment with Hympavzi of 3.2,

showing that Hympavzi was superior to on-demand factor replacement. In the initial six-month period during which patients received prophylactic factor replacement, the estimated annualized bleeding rate was 7.85 and was 5.08 during the subsequent 12 months on Hympavzi prophylaxis, showing that Hympavzi provided similar bleeding rates. The most common side effects of Hympavzi are injection site reactions, headache and pruritis.

IV. Initial Approval Criteria [1-3,8,10-11]

Coverage is provided in the following conditions:

- Member is at least 6 years of age; **AND**
- Hympavzi must be prescribed by, or consultation with a hematologist; **AND**
- Member will initiate maintenance therapy at the lower range of dosing (i.e., 75 mg every week for pediatric members 6 to < 12 years of age or 150 mg every week for adults and pediatric members ≥ 12 years of age); **AND**
- Will not be used for the treatment of breakthrough bleeds *(Note: Factor VIII or Factor IX products may be administered on an as needed basis for the treatment of breakthrough bleeds in members being treated with Hympavzi(marstacimab)*; **AND**
- Female members of reproductive potential are not pregnant prior to initiating therapy with Hympavzi (marstacimab); **AND**
- Member does not have a history of coronary artery disease, venous or arterial thrombosis or ischemic disease.

Universal Criteria

- Will not be used in combination with clotting factor products (i.e., factor VIII or factor IX concentrates) or Hemlibra as prophylactic therapy – *Therapy can be initiated at any time after discontinuing clotting factor concentrates (Note: factor VIII or factor IX products can be administered for the treatment of breakthrough bleeds while receiving marstacimab)*; ***See chart below **AND**
- Member has not previously received treatment with a gene therapy product (e.g., Roctavian) for the treatment of hemophilia A or a gene therapy product (e.g., Hemgenix) for the treatment of hemophilia B

Hemophilia (with or without factor VII or XI inhibitors) † Φ

- Member has a diagnosis of severe Hemophilia A (congenital factor VIII deficiency) or Hemophilia B (congenital factor IX deficiency aka Christmas Disease) as confirmed by blood coagulation testing *(Note: Severity defined as a FVIII level < 1% or FIX level ≤ 2%)*; **AND**
- One of the following apply:
- Used as treatment in one of the following:
    - Primary prophylaxis in members with severe factor VIII deficiency (factor VIII level of <1%); **OR**
    - Secondary prophylaxis in members with at least TWO documented episodes of spontaneous bleeding into joints**; AND**
- One of the following apply:
    - Member has Hemophilia A without inhibitors; **AND**
        - Member has tried and had an inadequate response to Hemlibra (emicizumab) AND an antihemophilic Factor VIII agent (e.g., Advate, Koate/Koate DVI, Hemofil, etc.) and, that are used for prophylaxis, unless contraindicated or not tolerated; **OR**

- Member has Hemophilia A with inhibitors; **AND**
    - Member has had previous prophylaxis therapy with an antihemophilic Factor VIII agent product (e.g., Advate, Koate/Koate DVI, Hemofil, etc. with bypassing agent [i.e., Novoseven, FEIBA, etc.]); **OR**
- Member has Hemophilia B without inhibitors; **AND**
    - Member has tried and had an inadequate response to an antihemophilic Factor IX(e.g., Benefit, Alprolix, Idelvion, Rebinyn, etc.) agent used for prophylaxis, unless contraindicated or not tolerated; **OR**
- Member has Hemophilia B with inhibitors; **AND**
    - Member has had previous prophylaxis therapy with an antihemophilic Factor IX agent (e.g., Benefit, Alprolix, Idelvion, Rebinyn, etc. with bypassing agents, [i.e., Novoseven, FEIBA, etc.])

† FDA Approved Indication(s); ‡ Compendia Recommended Indication(s); **Φ** Orphan Drug

******Drugs to treat Hemophilia A or B***

Hemophilia A & B Drug Chart	
Factor VIIa (Hemophilia A or B)	
Novoseven RT	J7189
Sevenfact	J7212
Anti-Inhibitor Coagulant Complex (Hemophilia A or B)	
Feiba	J7198
Factor VIII (Hemophilia A)	
Advate	J7192
Kogenate FS	J7192
Helixate FS	J7192
Recombinate	J7192
Kovaltry	J7211
Eloctate	J7205
Koate / Koate-DVI	J7190
Hemofil M	J7190

Novoeight	J7182
Nuwiq	J7209
Obizur	J7188
Xyntha / Xyntha Solofuse	J7185
Afstyla	J7210
Adynovate	J7207
Jivi	J7208
Esperoct	J7204
Altuviiio	J7214
Humate-P	J7187
Alphanate	J7186
Wilate	J7183
Hemlibra	J7170
Factor IX (Hemophilia B)	
AlphaNine SD	J7193
Mononine	J7193
Alprolix	J7201
Profilnine	J7194
BeneFIX	J7194
Ixinity	J7213
Rixubis	J7200
Idelvion	J7202
Rebinyn	J7203
Tissue Factor Pathway Inhibitor (Hemophilia A or B)	
Alhemo	J7173

Hympavzi	J7172
Antithrombin-Directed Double-Stranded Small Interfering Ribonucleic acid (siRNA) (Hemophilia A or B)	
Qfitlia	J7174

V. Renewal Criteria [1-3,8]

Coverage can be renewed based upon the following criteria:

- Member continues to meet the indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section IV; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: thromboembolic events, hypersensitivity, etc.; **AND**
    - Member has demonstrated a beneficial response to therapy (i.e., the frequency of bleeding episodes has decreased from pre-treatment baseline); **OR**
    - Member requires a dose escalation* (up to the maximum dose and frequency specified below) provided that the member meets all the following criteria:
        - Member weighs greater than or equal to 50 kg
        - Control of bleeding events has been inadequate (i.e., member has experienced two or more breakthrough bleeds while on maintenance therapy at the lower dose)
        - Member has been fully adherent to maintenance therapy for at least six months at the lower dose

**Note: Safety and efficacy of Hympavzi at doses above 300 mg weekly has not been established.*

VI. Dosage/Administration [1]

Indication	Dose
Routine Prophylaxis in Congenital Hemophilia A or Hemophilia B without inhibitors	**<u>Loading Dose</u>:** • 300 mg (two 150 mg subcutaneous injections) **<u>Maintenance Dose:</u>** • One week after the loading dose, initiate maintenance dosing of 150 mg every week by subcutaneous injection on the same day each week, at any time of day. • Consider a dose adjustment to 300 mg subcutaneous injection weekly in patients weighing greater than or equal to 50 kg when control of bleeding events is judged to be inadequate by the healthcare provider. Safety and efficacy of Hympavzi at doses above 300 mg weekly have not been established.

Indication	Dose
	If more than one injection is required to deliver a complete dose, administer each injection at a different injection site.

- Hympavzi is intended for use under the guidance of a healthcare provider. After proper training in subcutaneous injection technique, a patient may self-inject or the patient's caregiver may administer it, if a healthcare provider determines that it is appropriate.

VII. Billing Code/Availability Information

HCPCS Code:

- J7172 – injection, marstacimab-hncq, 0.5mg

NDC:

- Hympavzi single-dose prefilled syringe: 00069-1510-xx
- Hympavzi single-dose prefilled pen: 00069-2151-xx

VIII. References

1. Hympavzi [package insert]. New York, NY; Pfizer, Inc. June 2026. Accessed June 2026.
2. MASAC Recommendations Concerning Products Licensed for the Treatment of Hemophilia and Selected Disorders of the Coagulation System. Revised April 11, 2024. National Hemophilia Foundation. MASAC Document #284; April 2024. Available at: https://www.bleeding.org. Accessed May 2024.
3. Guidelines for the Management of Hemophilia. 3rd Edition. World Federation of Hemophilia 2020. Available at: https://www1.wfh.org/publications/files/pdf-1863.pdf. Accessed May 2024.
4. Annual Review of Factor Replacement Products. Oklahoma Health Care Authority Review Board. Updated Dec 2020. Accessed May 2024.
5. Graham A1, Jaworski K. Pharmacokinetic analysis of anti-hemophilic factor in the obese patient. Haemophilia. 2014 Mar;20(2):226-9.
6. Croteau SE1, Neufeld EJ. Transition considerations for extended half-life factor products. Haemophilia. 2015 May;21(3):285-8.
7. Mingot-Castellano, et al. Application of Pharmacokinetics Programs in Optimization of Haemostatic Treatment in Severe Hemophilia a Patients: Changes in Consumption, Clinical Outcomes and Quality of Life. Blood. 2014 December; 124 (21).
8. MASAC Recommendation Concerning Prophylaxis for Hemophilia A and B with and without Inhibitors. Revised April 27, 2022. National Hemophilia Foundation. MASAC Document #267; April 2022. Available at: https://www.bleeding.org. Accessed May 2024.
9. UKHCDO protocol for first line immune tolerance induction for children with severe haemophilia A: A protocol from the UKHCDO Inhibitor and Paediatric Working Parties. 2017. Available at: http://www.ukhcdo.org/guidelines. Accessed May 2024.
10. Hoots, WK. (2024). Hemophilia A and B: Routine management including prophylaxis. In Leung LLK, Tirnauer JS (Eds.), *UptoDate*. Last updated: April 16, 2024. Accessed May 13, 2024. Available from https://www.uptodate.com/contents/hemophilia-a-and-b-routine-management-including-prophylaxis?search=hemophilia%20a&source=search_result&selectedTitle=2~150&usage_type=default&display_rank=2#H978189854.

11. Matino D, Acharya S, Palladino A, et al. Efficacy and Safety of the Anti-Tissue Factor Pathway Inhibitor Marstacimab in Participants with Severe Hemophilia without Inhibitors: Results from the Phase 3 Basis Trial. Blood, Volume 142, Supplement 1, 2023, Page 285, ISSN 0006-4971, https://doi.org/10.1182/blood-2023-181263.

Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
D66	Hereditary factor VIII deficiency
D67	Hereditary factor IX deficiency