



Drug Coverage Policy

Effective Date 10/15/2025

Coverage Policy Number IP0731

Policy Title Hympavzi

Hemophilia – Non-Factor Routine Prophylaxis Products – Hympavzi

- Hympavzi™ (marstacimab-hncq subcutaneous injection – Pfizer)

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

Hypmavzi, a tissue factor pathway inhibitor antagonist, is indicated for routine prophylaxis to prevent or reduce the frequency of bleeding episodes in patients ≥ 12 years of age with 1) hemophilia A (congenital Factor VIII deficiency) without Factor VIII inhibitors, and 2) hemophilia B (congenital Factor IX deficiency) without Factor IX inhibitors.¹

Hypmavzi is recommended to be given as a 300 mg loading dose by subcutaneous injection (two 150 mg subcutaneous injections).¹ One week after the loading dose, initiate maintenance dosing of 150 mg once weekly by subcutaneous injection on the same day each week, at any time of the day. After proper training, Hypmavzi may be self-administered.

Disease Overview

Hemophilia A and B are genetic bleeding disorders caused by a dysfunction or a deficiency of coagulation Factor VIII and Factor IX, respectively.²⁻⁷ Because hemophilia is an X-linked condition, males are primarily impacted. Patients who have these types of hemophilias are not able to properly form clots in the blood and may bleed for a longer time than normal following injury or surgery. Patients may also experience spontaneous bleeding in muscles, joints, and organs. Bleeds may be life-threatening. A main morbidity is hemophilic arthropathy, which limits mobility. It is estimated that 33,000 males are living with hemophilia in the US; hemophilia A accounts for around 80% of the cases (approximately 26,400 patients) and hemophilia B comprises 20% of cases (around 6,600 patients). Hemophilias are often classified as mild, moderate, or severe based on reduced Factor VIII or IX levels. Approximately 50% and 30% of patients with hemophilia A and hemophilia B, respectively, have severe disease. The formation of antibodies (or inhibitors) to factor products is a challenging complication as it causes Factor VIII and Factor IX therapies to be ineffective, which increases bleeding frequency and severity. Antibodies develop in around 30% and 10% of patients with severe hemophilia A and hemophilia B, respectively.

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Policy Statement

Prior Authorization is required for benefit coverage of Hypmavzi. All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of patients treated with Hypmavzi as well as the monitoring required for adverse events and long-term efficacy, approval requires Hypmavzi to be prescribed by or in consultation with a hemophilia specialist.

Documentation: Documentation is required where noted in the criteria as **[documentation required]**. Documentation may include, but not limited to, chart notes, laboratory tests, claims records, and/or other information.

Hypmavzi is considered medically necessary when ONE of the following is met (1 or 2):

FDA-Approved Indications

- 1. Hemophilia A without Factor VIII Inhibitors.** Approve for 1 year if the patient meets ONE of the following (A or B):
 - A) Initial Therapy.** Approve if the patient meets ALL of the following (i, ii, iii, iv, v, and vi):
 - i. Patient is ≥ 12 years of age; AND
 - ii. Patient is using Hypmavzi for routine prophylaxis to prevent or reduce the frequency of bleeding episodes; AND

- iii. Patient has moderately severe to severe hemophilia A as evidenced by a baseline (without Factor VIII replacement therapy) Factor VIII level of $\leq 2\%$ **[documentation required]**; AND
 - iv. Patient meets ONE of the following (a or b):
 - a) Patient meets BOTH of the following [(1) and (2)]:
 - (1) Factor VIII inhibitor titer testing has been performed within the past 30 days **[documentation required]**; AND
 - (2) Patient does not have a positive test for Factor VIII inhibitors of ≥ 1.0 Bethesda units/mL **[documentation required]**; OR
 - b) Patient has not received Factor VIII therapy in the past; AND
 - v. According to the prescriber, prophylactic use of Factor VIII products will be discontinued; AND

Note: Use of Factor VIII products for the treatment of breakthrough bleeding is permitted.
 - vi. The medication is prescribed by or in consultation with a hemophilia specialist; OR
- B) Patient is Currently Receiving Hympavzi.** Approve if the patient meets ALL of the following (i, ii, iii, and iv):
- i. Patient is using Hympavzi for routine prophylaxis to prevent or reduce the frequency of bleeding episodes; AND
 - ii. According to the prescriber, prophylactic use of Factor VIII products will not occur while receiving Hympavzi; AND

Note: Use of Factor VIII products for the treatment of breakthrough bleeding is permitted.
 - iii. The medication is prescribed by or in consultation with a hemophilia specialist; AND
 - iv. According to the prescriber, patient experienced a beneficial response to therapy.

Note: Examples of a beneficial response to therapy include a reduction in bleeding events, in the severity of bleeding episodes, in the number of bleeding events that required treatment, and/or in the number of spontaneous bleeds.

2. Hemophilia B without Factor IX Inhibitors. Approve for 1 year if the patient meets ONE of the following (A or B):

- A) Initial Therapy.** Approve if the patient meets ALL of the following (i, ii, iii, iv, v, and vi):
- i. Patient is ≥ 12 years of age; AND
 - ii. Patient is using Hympavzi for routine prophylaxis to prevent or reduce the frequency of bleeding episodes; AND
 - iii. Patient has moderately severe to severe hemophilia B as evidenced by a baseline (without Factor IX replacement therapy) Factor IX level $\leq 2\%$ **[documentation required]**; AND
 - iv. Patient meets ONE of the following (a or b):
 - a) Patient meets BOTH of the following [(1) and (2)]:
 - (1) Factor IX inhibitor titer testing has been performed within the past 30 days **[documentation required]**; AND
 - (2) Patient does not have a positive test for Factor IX inhibitors of ≥ 1.0 Bethesda units/mL **[documentation required]**; OR
 - b) Patient has not received Factor IX therapy in the past; AND
 - v. According to the prescriber, prophylactic use of Factor IX products will be discontinued; AND

Note: Use of Factor IX products for the treatment of breakthrough bleeding is permitted.
 - vi. The medication is prescribed by or in consultation with a hemophilia specialist; OR

- B) Patient is Currently Receiving Hympavzi.** Approve if the patient meets ALL of the following (i, ii, iii, and iv):
- i.** Patient is using Hympavzi for routine prophylaxis to prevent or reduce the frequency of bleeding episodes; AND
 - ii.** According to the prescriber, prophylactic use of Factor IX products will not occur while receiving Hympavzi; AND
Note: Use of Factor IX products for the treatment of breakthrough bleeding is permitted.
 - iii.** The medication is prescribed by or in consultation with a hemophilia specialist; AND
 - iv.** According to the prescriber, patient experienced a beneficial response to therapy.
Note: Examples of a beneficial response to therapy include a reduction in bleeding events, in the severity of bleeding episodes, in the number of bleeding events that required treatment, and/or in the number of spontaneous bleeds.

Conditions Not Covered

Hympavzi for any other use is considered not medically necessary, including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

- 1. Concurrent Use with Alhemo (concizumab-mtci subcutaneous injection), Hemlibra (emicizumab-kxwh subcutaneous injection), or Qfitlia (fitusiran subcutaneous injection)** . These are also non-factor products used for routine prophylaxis in hemophilia A and/or B.⁸⁻¹⁰ There is no evidence to support concomitant use of Hympavzi with Alhemo, Hemlibra, or Qfitlia.

Coding Information

- Note:** 1) This list of codes may not be all-inclusive.
 2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

| HCPCS Codes | Description |
|--------------------|-------------------------------------|
| J7172 | Injection, marstacimab-hncq, 0.5 mg |

References

1. Hympavzi™ subcutaneous injection [prescribing information]. New York, NY: Pfizer; October 2024.
2. Chowdary P, Carcao M, Kenet G, Pipe SW. Haemophilia. *Lancet*. 2025;405(10480):736-750.
3. Franchini M, Mannucci PM. The more recent history of hemophilia treatment. *Semin Thromb Hemost*. 2022;48(8):904-910.
4. Croteau SE. Hemophilia A/B. *Hematol Oncol Clin North Am*. 2022;36(4):797-812.

5. Centers for Disease Control and Prevention. Data and statistics on hemophilia. Available at: <https://www.cdc.gov/hemophilia/data-research/>. Accessed on June 6, 2025.
6. National Bleeding Disorders Foundation. Hemophilia A: An overview of symptoms, genetics, and treatments to help you understand hemophilia B. Available at: <https://www.bleeding.org/bleeding-disorders-a-z/types/hemophilia-a>. Accessed on June 6, 2025.
7. National Hemophilia Foundation. Hemophilia B. An overview of symptoms, genetics, and treatments to help you understand hemophilia B. Available at: <https://www.hemophilia.org/bleeding-disorders-a-z/types/hemophilia-b>. Accessed on June 6, 2025.
8. Alhemo® subcutaneous injection [prescribing information]. Plainsboro, NJ: Novo Nordisk; May 2025.
9. Hemlibra® subcutaneous injection [prescribing information]. South San Francisco, CA and Tokyo, Japan: Genentech/Roche and Chugai; January 2024.
10. Qfitlia™ subcutaneous injection [prescribing information]. Cambridge, MA: Genzyme/Sanofi; March 2025.

Revision Details

| Type of Revision | Summary of Changes | Date |
|-------------------|--|------------|
| New | New policy | 05/15/2025 |
| Selected Revision | <p>Preferred Product Criteria – Employer Plans: Updated preferred product criteria</p> <p>Removed “Approve if, according to the prescriber, there is concern for a drug-drug interaction (e.g., drug interaction with Hemlibra and Feiba”</p> <p>Added documentation requirements throughout the policy.</p> | 07/15/2025 |
| Annual Revision | <p>“Non-Factor Routine Prophylaxis Products” was added to the title of the Policy. In addition, the following changes were made:</p> <p>Hemophilia A without Factor VIII Inhibitors: In <u>Initial Therapy</u>, the requirement that “Patient has severe hemophilia A as evidence by a baseline (without Factor VIII replacement therapy) Factor VIII level of < 1%” was changed to “Patient has moderate to severe hemophilia A as evidenced by a baseline (without Factor VIII replacement therapy) Factor VIII level of ≤ 2%”. Regarding prophylactic use of Factor VIII products, the phrase “will not occur while using Hympavzi” was changed to “will be discontinued.” For a <u>Patient Currently Receiving Hympavzi</u>, for the criteria regarding prophylactic use of Factor VIII products, the word “using” was changed to “receiving.”</p> | 8/15/2025 |

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|-------------------|--|------------|
| | <p>Hemophilia B without Factor IX Inhibitors: In <u>Initial Therapy</u>, the wording “moderately severe or severe hemophilia B” was changed to “moderately severe to severe hemophilia B.” Regarding prophylactic use of Factor IX products, the phrase “will not occur while using Hymravzi” was changed to “will be discontinued.” For a <u>Patient Currently Receiving Hymravzi</u>, for the criteria regarding prophylactic use of Factor IX products, the word “using” was changed to “receiving.” In the Note regarding examples of a beneficial response, the phrase “to therapy” was added and “spontaneous bleeding events” was changed to “spontaneous bleeds.”</p> <p>Conditions Not Recommended for Approval: Qfitlia was added as a medication that should not be used concurrently with Hymravzi.</p> <p>Coding Information: Added HCPCS Coding Table Added Code: J1712</p> | |
| Selected Revision | Removed preferred product table from Employer Plans | 10/1/2025 |
| Selected Revision | Updated policy template. | 10/15/2025 |

The policy effective date is in force until updated or retired.

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