SENTARA HEALTH PLANS

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-844-668-1550**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Drug Requested: Hympavzi™ (marstacimab-hncq) (J7172) (Medical)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Dosing Limits:

A. Quantity Limit (max daily dose) [NDC Unit]:

- 150 mg/mL in a single-dose prefilled pen once weekly = 300 billable units per pen
- 75 mg/mL in a single-dose prefilled pen once weekly = 150 billable units per pen
- NDC 00069-2151-01 (150 mg/mL): 4 syringes/pens per 28 days
- NDC 00069-0775-01 (75 mg/mL): 8 syringes/pens per 28 days

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 12 months

- ❑ Member is ≥ 6 years of age
- ❑ Medication prescribed by a specialist familiar with treating patients with hemophilia (factor VIII or IX deficiency)
- ❑ Female patients of reproductive potential are **NOT** pregnant prior to initiating therapy with marstacimab
- ❑ Requested medication marstacimab will **NOT** be used in combination with clotting factor replacement products (i.e., factor VIII or factor IX concentrates), Hemlibra® (emicizumab-kxwh) in those with hemophilia A as prophylactic therapy, and Alhemo® (concizumab-mtci) or Qfitlia® (fitusiran) in those with hemophilia A or hemophilia B as prophylactic therapy
- ❑ Marstacimab 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 patients being treated with marstacimab)
- ❑ Member does **NOT** have a history of, or is on current treatment for, coronary artery diseases, venous or arterial thrombosis, or ischemic disease
- ❑ Member meets **ONE** of the following diagnosis conditions:
  - ❑ Member has a diagnosis of **Hemophilia A** (congenital factor VIII deficiency) and meets **ALL** the following:
    - ❑ Diagnosis of congenital factor VIII deficiency has been confirmed by blood coagulation testing
    - ❑ A level of severe hemophilia A is documented by a factor VIII activity level < 1 IU/dL (in the absence of exogenous factor VIII) **(Assay results for activity level documentation required)**
    - ❑ Member has been tested and found negative for active factor VIII inhibitors (i.e., results from a Bethesda assay or Bethesda assay with Nijmegen modification of less than 0.6 Bethesda Units (BU) has been performed within the past 30 days and submitted) and is **NOT** receiving a bypassing agent (e.g., Feiba, Sevenfact)
    - ❑ Member has **NOT** received prior gene therapy for hemophilia A (e.g., Roctavian® (valoctocogene roxaparvovec-rvox))
    - ❑ Member meets **ONE** of the following:
      - ❑ Member has a history of life-threatening hemorrhage requiring on-demand use of Factor VIII therapy
      - ❑ Member has a history of repeated, serious spontaneous bleeding episodes requiring on-demand use of Factor VIII therapy was required for these serious spontaneous bleeding episodes

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- ❑ Member has a diagnosis of **Hemophilia B** (congenital factor IX deficiency) and meets **ALL** the following:
  - ❑ Diagnosis of congenital factor IX deficiency has been confirmed by blood coagulation testing
  - ❑ A level of moderately severe to severe hemophilia B is documented by a factor IX activity level ≤ 2 IU/dL (in the absence of exogenous factor IX) **(Assay results for activity level documentation required)**
  - ❑ Member has been tested and found negative for active factor IX inhibitors (i.e., results from a Bethesda assay or Bethesda assay with Nijmegen modification of less than 0.6 Bethesda Units (BU) has been performed within the past 30 days and submitted) and is **NOT** receiving a bypassing agent (e.g., Feiba, Sevenfact)
  - ❑ Member has **NOT** received prior gene therapy for hemophilia B (e.g., Hemgenix® (etranacogene dezaparvovec-drlb), Beqvez™ (fidanacogene elaparvovec-dzkt))
  - ❑ Member meets **ONE** of the following:
    - ❑ Member has a history of life-threatening hemorrhage requiring on-demand use of Factor IX therapy
    - ❑ Member has a history of repeated, serious spontaneous bleeding episodes requiring on-demand use of Factor IX therapy was required for these serious spontaneous bleeding episode

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member continues to meet the indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, dosing recommendations, etc. identified in the Initial Criteria section
- ❑ Member has **NOT** experienced any unacceptable toxicity from the drug (e.g., thromboembolic events, hypersensitivity)
- ❑ Member has demonstrated a beneficial response to therapy (i.e., the frequency of bleeding episodes has decreased from pre-treatment baseline, in severity of bleeding episodes, and/or in the number of spontaneous bleeding events) [**NOTE:** providers must submit well-documented, quantitative assessment of bleeding events since initiating marstacimab therapy]
- ❑ **For Adults and Pediatric Patients 12 Years of Age and Older,** if titration to 300 mg once weekly dosing is medically necessary, **ALL** the following must be met:
  - ❑ Member's current weight is greater than or equal to 50 kg
  - ❑ Control of bleeding events has been inadequate (**NOTE:** providers must submit well-documented, quantitative assessment of two or more breakthrough bleeding events while on maintenance therapy at the lower dose of 150 mg in the past six months)
  - ❑ Member has been fully adherent to maintenance therapy for at least six months at the lower dose **(verified by chart notes and/or pharmacy paid claims)**

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- ❑ **For Pediatric Patients 6 to less than 12 Years of Age,** if titration to 150 mg (one 150 mg subcutaneous injection or two 75 mg subcutaneous injections) once weekly dosing is medically necessary, **ALL** the following must be met:
  - ❑ Member's current weight is greater than or equal to 25 kg
  - ❑ Control of bleeding events has been inadequate (**NOTE:** providers must submit well-documented, quantitative assessment of two or more breakthrough bleeding events while on maintenance therapy at the lower dose of 75 mg in the past six months)
  - ❑ Member has been fully adherent to maintenance therapy for at least six months at the lower dose **(verified by chart notes and/or pharmacy paid claims)**

Medication being provided by (check applicable box(es) below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy**

For urgent reviews: Practitioner should call Sentara Health Plans Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health Plan's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: ~~1/23/2025;~~ **7/23/2026**
REVISED/UPDATED/REFORMATTED: ~~2/19/2025; 6/18/2025;~~ **8/28/2026**