SPECIALTY GUIDELINE MANAGEMENT

REBINYN (coagulation factor IX [recombinant], glycoPEGylated)

IDELVION (coagulation factor IX [recombinant], albumin fusion protein)

ALPROLIX (coagulation factor IX [recombinant], Fc fusion protein)

BENEFIX, IXINITY, RIXUBIS (coagulation factor IX [recombinant])

ALPHANINE SD, MONONINE (coagulation factor IX [human])

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication

Hemophilia B

All other indications are considered experimental/investigational and not medically necessary.

II. CRITERIA FOR INITIAL APPROVAL

Hemophilia B

Authorization of 12 months may be granted for treatment of hemophilia B.

III. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in Section II when the member is experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds).

IV. REFERENCES