Reference number(s)
7363-D

This document applies to the following:

Formulary	Applies
Standard Control (SF)	☑
Standard Control Choice (SCCF)	☑
Preferred Drug Plan Design (PDPD)	☐
Advanced Control Specialty (ACSF)	☑
Advanced Control Specialty Choice (ACSCF)	☑
Managed Medicaid Template (MMT)	☐
Marketplace (MF)	☐
Aetna Small Group Affordable Care Act (SG ACA) Aetna Health Exchange (AHE)	☐
Value (VF)	☑

Formulary	Applies
New to Market (NTM)	☐
Standard Formulary Chart (SFC)	☑
Basic Control Chart Preferred Drug Plan Design (BCC PDPD)	☐
Advanced Control Specialty Formulary Chart (ACSFC)	☑
Value Formulary Chart (VFC)	☑
Medical Benefit	☐
Medical Benefit: Advanced Biosimilars First	☐
Combined Benefit Management (CBM)	☐
Combined Benefit Management Pharmacy (CBMP)	☐
Medical Benefit Managed Medicaid (MMMB)	☐

Exceptions Criteria
Hemophilia A Products

This document informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

These criteria were developed to align with the following: Standard Control Formulary (SF), Standard Control Choice Formulary (SCCF), Advanced Control Specialty Formulary (ACSF), Advanced Control Specialty – Choice Formulary (ACSCF), Value Formulary (VF), Standard Formulary Chart (SFC), Advanced Control Specialty Formulary Chart (ACSFC), and Value Formulary Chart (VFC).

Plan Design Summary

This program applies to the hemophilia A products specified in this document. Coverage for the targeted product is provided based on clinical circumstances that would exclude the use of the preferred products and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to members who are new to treatment with a targeted product for the first time.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table. Hemophilia A Products

Medications considered formulary or preferred on your plan may still require a clinical prior authorization review.

	Products
Preferred	• Hemlibra (emicizumab-kxwh)
Target	• Alhemo (concizumab-mtci) • Hympavzi (marstacimab-hncq) • Qfitlia (fitusiran)

Exception Criteria

This program applies to members requesting treatment for an indication that is FDA-approved for the preferred products.

Coverage for a targeted product is provided when any of the following criteria are met:

- Member is currently receiving treatment with a targeted product, excluding when the requested targeted product is obtained as samples or via manufacturer's patient assistance programs.
- Member has a documented inadequate response or intolerable adverse event with the preferred product.

References

1. Alhemo [package insert]. Plainsboro, NJ: Novo Nordisk Inc.; July 2025.
2. Hemlibra [package insert]. South San Francisco, CA: Genentech, Inc.; July 2025.
3. Hympavzi [package insert]. New York, NY: Pfizer Inc.; September 2025.
4. Qfitlia [package insert]. Cambridge, MA: Genzyme Corporation; September 2025.

