

Specialty Guideline Management

Hypavzi

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Hypavzi	marstacimab-hncq

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 Indications¹

Hypavzi 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 (congenital factor VIII deficiency) without factor VIII inhibitors, or
- Hemophilia B (congenital factor IX deficiency) without factor IX inhibitors.

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

Documentation

Submission of the following information is necessary to initiate the prior authorization review:

For initial requests: Chart notes, lab tests documenting all of the following (where applicable):
Hemophilia A (congenital factor VIII deficiency):

Reference number(s)
6702-A

- Severe factor VIII deficiency (factor VIII level of <1%)
- Absence of factor VIII inhibitors (lab test results required)

Hemophilia B (congenital factor IX deficiency):

- Moderately severe to severe factor IX deficiency (factor IX level of $\leq 2\%$)
- Absence of Factor IX inhibitors (lab test results required)

For continuation requests: Chart notes documenting benefit from therapy (e.g., reduced frequency or severity of bleeds).

Prescriber Specialties

The medication must be prescribed by or in consultation with a hematologist.

Coverage Criteria

Hemophilia A (congenital factor VIII deficiency)^{1,2}

Authorization of 12 months may be granted for hemophilia A (congenital factor VIII deficiency) when all of the following criteria are met:

- Member is 6 years of age or older.
- Member has severe factor VIII deficiency (defined as factor VIII level of <1%).
- Member has no detectable or documented history of factor VIII inhibitors.
- Member must be using the requested medication for routine prophylaxis to prevent or reduce the frequency of bleeding episodes.
- Member will not use the requested medication to treat breakthrough bleeding.
- Member does not have a history of coronary artery disease, venous or arterial thrombosis or ischemic disease.
- Member does not have unstable or abnormal hepatic, biliary, or renal function/disease.
- Member will not use the requested medication in combination with Alhemo, Hemlibra, or Qfitlia.
- Member has not previously received treatment with a gene therapy product (e.g., Roctavian) for the treatment of hemophilia A.
- Prophylactic use of factor VIII products will be discontinued prior to starting therapy with the requested medication.

Hemophilia B (congenital factor IX deficiency)^{1,2}

Authorization of 12 months may be granted for hemophilia B (congenital factor IX deficiency) when all of the following criteria are met:

- Member is 6 years of age or older.

- Member has moderately severe to severe factor IX deficiency (defined as factor IX level of $\leq$ 2%).
- Member has no detectable or documented history of factor IX inhibitors.
- Member must be using the requested medication for routine prophylaxis to prevent or reduce the frequency of bleeding episodes.
- Member will not use the requested medication to treat breakthrough bleeding.
- Member does not have a history of coronary artery disease, venous or arterial thrombosis or ischemic disease.
- Member does not have unstable or abnormal hepatic, biliary, or renal function/disease.
- Member will not use the requested medication in combination with Alhemo or Qfitlia.
- Member has not previously received treatment with a gene therapy product (e.g., Hemgenix) for the treatment of hemophilia B.
- Prophylactic use of factor IX products will be discontinued prior to starting therapy with the requested medication.

Continuation of Therapy

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in coverage criteria section when all of the following are met:

- Member is experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds).
- Member has no detectable or documented history of factor VIII or IX inhibitors.
- Member is not using the requested medication in combination with factor VIII products (e.g., Advate, Adynovate, Eloctate) or factor IX products (e.g., Alprolix, Ixinity, Rebinyn) for prophylactic use.

References

1. Hymravzi [package insert]. New York, NY: Pfizer Inc.; June 2026.
2. Davide Matino, Suchitra Acharya, Andrew Palladino, Eunhee Hwang, Regina McDonald, Carrie Turich Taylor, John Teeter; 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* 2023; 142 (Supplement 1): 285.