Hympavzi *(marstacimab-hncq)*

PA Criteria	Criteria Details
Covered Uses (FDA approved indication)	Hympavzi is an anti-tissue factor pathway inhibitor (anti-TFPI) product indicated for the routine prophylaxis to prevent or reduce frequency of bleeding episodes in adults and pediatric patients ≥ 12 years of age with hemophilia A (congenital Factor VIII deficiency) without Factor VIII inhibitors or hemophilia B (congenital Factor IX deficiency) without Factor IX inhibitors.
Exclusion Criteria	None.
Required Medical Information	**For initial requests for Hemophilia A:** Medical records supporting the request must be provided and include documentation of the following: Hympavzi is being used for routine prophylaxis to prevent or reduce the frequency of bleeding episodes; Patient has moderate or severe hemophilia A (a clotting factor level <1% or between 1%- 5%) without factors; Patient has tried with failure (defined as continuing to have spontaneous bleeds) or intolerance, or has a contraindication to factor VIII prophylaxis therapy or Hemlibra. **For initial requests for Hemophilia B:** Medical records supporting the request must be provided and include documentation of the following: Hympavzi is being used for routine prophylaxis to prevent or reduce the frequency of bleeding episodes; Patient has moderate or severe hemophilia B (a clotting factor level <1% or between 1%- 5%) without factors; Patient has tried with failure (defined as continuing to have spontaneous bleeds) or intolerance, or has a contraindication to factor IX prophylaxis therapy. For reauthorization of hemophilia A and B: (1) Patient continues to use Hympavzi for routine prophylaxis to prevent or reduce the frequency of bleeding episodes; AND (2) Documentation of clinical benefit (e.g., less bleeding episodes; less use of factor VIII replacement therapy or bypassing agents) has been provided.
Age Restriction	Patient is at least 12 years of age.
Prescriber Restrictions	Must be prescribed by or in consultation with a hematologist or other specialist.
Coverage Duration	Initial and reauthorization: 12 months. Dose will be approved according to the FDA-approved labeling or within accepted standards of medical practice.

GOLD COAST HEALTH PLAN
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Other Criteria/Information	Refer to the Gold Coast Health Plan Medicare Part B Reference and Summary of Evidence document.

HCPCS	Description	Billing Units/How Supplied
J7172	Hympavzi (marstacimab-hncq), 0.5 mg injection	**Billing unit: 0.5 mg** 150 mg/ml SVD

STATUS	DATE REVISED	REVIEW DATE	APPROVED/REVIEWED BY	EFFECTIVE DATE
Created	3/26/2025	3/26/2025	Dawn Shojai, PharmD, Senior Pharmacy Benefit Consultant (PSG)	N/A
Approved	N/A	5/15/2025	Pharmacy & Therapeutics (P&T) Committee	5/15/2025