Clinical Policy: Factor IX Complex, Human (Profilnine)
Reference Number: CP.PHAR.219
Effective Date: 05.01.16
Last Review Date: 02.21
Line of Business: Commercial, Medicaid, HIM

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Factor IX complex (human) (Profilnine®) contains factor IX, II, X, and low levels of factor VII.

FDA Approved Indication(s)
Profilnine is indicated for the prevention and control of bleeding episodes in adult patients with hemophilia B (congenital factor IX deficiency or Christmas disease).

Limitation(s) of use: Profilnine contains non-therapeutic levels of factor VII and is not indicated for use in the treatment of factor VII deficiency.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Profilnine is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Congenital Hemophilia B (must meet all):
      1. Diagnosis of congenital hemophilia B (factor IX deficiency);
      2. Prescribed by or in consultation with a hematologist;
      3. Age ≥ 18 years;
      4. Request is for prevention and control of bleeding episodes;
      5. Documentation of member’s current body weight (in kg);
      6. Dose does not exceed the FDA approved maximum recommended dose for the relevant indication.
   
   Approval duration: 3 months

   B. Other diagnoses/indications
      1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.
II. Continued Therapy
A. Congenital Hemophilia B (must meet all):
   1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   2. Member is responding positively to therapy;
   3. Documentation of member’s current body weight (in kg);
   4. If request is for a dose increase, new dose does not exceed the FDA approved maximum recommended dose for the relevant indication.

Approval duration: 3 months

B. Other diagnoses/indications (must meet 1 or 2):
   1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
      Approval duration: Duration of request or 3 months (whichever is less); or
   2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:
A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information
Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings
- Contraindication(s): none reported
- Boxed warning(s): none reported

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
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<tbody>
<tr>
<td>Factor IX complex (Profilnine)</td>
<td>Minor to moderate bleeding episodes: 20-30 IU/kg IV every 16-24 hours</td>
<td>50 IU/kg</td>
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<tr>
<td></td>
<td>Major bleeding episodes: 30-50 IU/kg IV followed by 20 IU/kg IV every 16-24 hours</td>
<td></td>
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</tbody>
</table>
VI. Product Availability
Vial: 500, 1,000, 1,500 IU

VII. References

Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
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<tr>
<td>J7194</td>
<td>Factor IX complex, per IU</td>
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<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
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<tbody>
<tr>
<td>Safety information removed. Wording, approval periods, and use of “congenital” versus “acquired hemophilia descriptions made consistent across all blood factor policies. Efficacy statement added to renewal criteria. Reviewed by specialist- hematology/ internal medicine.</td>
<td>04.01.17</td>
<td>05.17</td>
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</tbody>
</table>
| 1Q18 annual review:  
- Converted to new template  
- Changed age limit for Profilnine to 18 years, per PI  
- References reviewed and updated | 11.28.17   | 02.18             |
| 1Q 2019 annual review: added HIM-Medical Benefit; no significant changes; references reviewed and updated. | 09.26.18   | 02.19             |
| 1Q 2020 annual review: no significant changes; removed Bebulin from the policy as it is no longer available; references reviewed and updated. | 11.27.19   | 02.20             |
## Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.
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**Note: For Medicaid members,** when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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