

Clinical Policy Title:	Alhemo, Qfitlia
Policy Number:	RxA.904
Drug(s) Applied:	Alhemo, Qfitlia
Original Policy Date:	09/10/2025
Last Review Date:	12/11/2025
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Hemophilia A or B (must meet all):

1. Diagnosis of hemophilia A or B;
2. Patient has severe hemophilia as defined by factor VIII or IX level <1%;
3. Prescribed for prophylaxis of bleeding episodes;
4. Patient will discontinue use of other prophylactic therapies.

Approval duration

All Lines of Business (except Medicare): 12 months

II. Continued Therapy Approval

A. Hemophilia A or B (must meet all):

1. Auto-approval based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy.

Approval duration

All Lines of Business (except Medicare): 12 months

References

1. Young G, et al. Safety and efficacy of a fitusiran antithrombin-based dose regimen in people with hemophilia A or B: the ATLAS-OLE study. *Blood*. 2025. doi:10.1182/blood.2024027008
2. Rezende SM, Neumann I, Angchaisuksiri P, et al. International Society on Thrombosis and Haemostasis clinical practice guideline for treatment of congenital hemophilia A and B based on the Grading of Recommendations Assessment, Development, and Evaluation methodology. *J Thromb Haemost*. 2024;22(9):2629-2652. doi:10.1016/j.jtha.2024.05.026
3. Chowdary P, et al. Concizumab prophylaxis in people with haemophilia A or haemophilia B without inhibitors (explorer8): a prospective, multicentre, open-label, randomised, phase 3a trial [published correction appears in *Lancet Haematol*. 2024;11(12):e886. doi:10.1016/S2352-3026(24)00353-3]. *Lancet Haematol*. 2024;11(12):e891–e904. doi:10.1016/S2352-3026(24)00307-7
4. Astermark J, et al. Efficacy and safety of concizumab prophylaxis in patients with hemophilia a or b without inhibitors: 56-week cut-off results of the Phase 3 explorer8 study. *Blood*. 2023;142(suppl 1):2609. doi:10.1182/blood-2023-173118.

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	09/10/2025	09/10/2025
Policy reviewed	12/11/2025	12/11/2025