AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Adynovate, Altuviiio, Eloctate, Esperoct	Page:	1 of 4
Effective Date:	8/5/2025	Last Review Date:	6/20/2025
Applies to:	☒Illinois ☒Florida Kids ☒New Jersey ☒Maryland ☒Pennsylvania Kids ☒Kentucky PRMD		

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Adynovate, Altuviiio, Eloctate, and Esperoct under the patient's prescription drug benefit.

Description:

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.

Table: Factor VIII Concentrates and Covered Uses

Brand	Generic	FDA-Approved Indication(s)
Extended Half-life Recombinant Factor VIII Concentrates		
Adynovate	antihemophilic factor [recombinant], PEGylated	Hemophilia A
Altuviiio	antihemophilic factor [recombinant], Fc-VWF-XTEN fusion protein-ehtl	Hemophilia A
Eloctate	antihemophilic factor [recombinant], Fc fusion protein	Hemophilia A
Esperoct	antihemophilic factor [recombinant], **Glycopegylated-exei**	Hemophilia A

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

Applicable Drug List:

Adynovate
Altuviiio
Eloctate
Esperoct

Policy/Guideline:

Prescriber Specialty:
Must be prescribed by or in consultation with a hematologist.

Criteria for Initial Approval:

Hemophilia A
Authorization of 12 months of Adynovate, Altuviiio, Eloctate, or Esperoct may be granted for treatment of hemophilia A when EITHER of the following criteria is met:

1. Member has mild disease (see Appendix A) and has had an insufficient response to desmopressin or a documented clinical reason for not using desmopressin (see Appendix B).
2. Member has moderate or severe disease (see Appendix A).

Continuation of Therapy:
Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in criteria for initial approval when the member is experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds).

Appendix A: Classification of Hemophilia by Clotting Factor Level (% Activity) and Bleeding Episodes

Severity	Clotting Factor Level % activity*	Bleeding Episodes
Severe	<1%	Spontaneous bleeding episodes, predominantly into joints and muscles Severe bleeding with trauma, injury or surgery
Moderate	1% to 5%	Occasional spontaneous bleeding episodes Severe bleeding with trauma, injury or surgery
Mild	6% to 40%	Severe bleeding with serious injury, trauma or surgery

*Factor assay levels are required to determine the diagnosis and are of value in monitoring treatment response.

Appendix B: Clinical Reasons For Not Utilizing Desmopressin in Patients with Hemophilia A and Type 1, 2A, 2M and 2N VWD

A. Age < 2 years
B. Pregnancy
C. Fluid/electrolyte imbalance
D. High risk for cardiovascular or cerebrovascular disease (especially the elderly)
E. Predisposition to thrombus formation
F. Trauma requiring surgery
G. Life-threatening bleed
H. Contraindication or intolerance to desmopressin
I. Severe type 1 von Willebrand disease
J. Stimate Nasal Spray is unavailable due to backorder/shortage issues (where applicable)

Approval Duration and Quantity Restrictions:

Approval: 12 months

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