PROVIDER POLICIES & PROCEDURES

ROCTAVIAN® (VALOCTOCOGENE ROXAPARVOVEC-RVOX)

The primary purpose of this document is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP) with the information needed to support a medical necessity determination for Roctavian (valoctocogene roxaparvovec-rvox). By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

Hemophilia A is an X-linked recessive hereditary bleeding disorder caused by deficiency of coagulation factor VIII. It primarily affects males occurring in about 1 in 4000 to 1 in 5000 live male births. Approximately one-half to two-thirds have severe disease (factor VIII activity <1 percent of normal). Clinical manifestations of hemophilia are mainly related to bleeding from impaired hemostasis, sequelae from bleeding, or complications of coagulation factor infusion.

ROCTAVIAN (valoctocogene roxaparvovec-rvox) is an adeno-associated virus vector-based gene therapy indicated for the treatment of adults with severe hemophilia A (congenital factor VIII deficiency with factor VIII activity < 1 IU/dL) without pre-existing antibodies to adeno-associated virus serotype 5 detected by an FDA-approved test.

CLINICAL GUIDELINE

Coverage guidelines for the use of Roctavian will be made in accordance with the DSS definition of Medical Necessity. The following criteria are guidelines *only*. Coverage guidelines are based on an assessment of the individual and their unique clinical needs. If the guidelines conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail. The guidelines are as follows:

Initial Requests

Roctavian (valoctocogene roxaparvovec-rvox) may be considered medically necessary for individuals with severe hemophilia A when the following criteria are met:

A. The individual is 18 years of age or older; **AND**
B. Medical record documentation confirming the diagnosis of severe hemophilia A as evidenced by endogenous Factor VIII levels ≤ 1 IU/dL; **AND**
C. The treatment is prescribed by or in consultation with a hematologist; **AND**
D. Baseline labs have been conducted confirming ALL of the following:
    a. Absence of pre-existing antibodies to AAV5 as confirmed by an FDA-approved test (e.g., AAV5 DetectCDX™); **AND**
    b. Platelet count ≥ 100 x 10^9/L; **AND**
    c. Creatinine < 1.4 mg/dL; **AND**
    d. A negative Factor VIII inhibitor test (≥0.6 Bethesda Units [BU]) within the last 30 days; **AND**

E. The treating provider attests to ALL of the following:
    a. The individual is currently undergoing treatment with Factor VIII prophylaxis, and has a history of prophylactic Factor VIII use for at least 150 exposure days**; AND**
    b. The individual does NOT have ANY of the following:
        i. Any history of inhibitors to Factor VIII; **AND**
        ii. Any active infections, either acute or uncontrolled chronic including:
            1. Acute respiratory infections; **AND**
            2. Acute hepatitis; **AND**
            3. Chronic or active hepatitis B; **AND**
            4. Active hepatitis C as evidenced by detectable HCV RNA or currently on antiviral therapy; **AND**
            5. Human immunodeficiency virus (HIV) infection; **AND**
        iii. An immunosuppressive disorder; **AND**
        iv. Significant liver disease as defined by the following:
            1. Alanine aminotransferase (ALT), aspartate aminotransferase (AST), gamma glutamyl transferase (GGT), total bilirubin, or alkaline phosphatase >1.25x ULN; **AND**
            2. International normalized ratio (INR) ≥1.4; **AND**
            3. Hepatic fibrosis (stage 3 or 4 on the Batts-Ludwig scale or equivalent); **AND**
            4. Cirrhosis of any etiology as assessed by liver ultrasound; **AND**
            5. History of hepatic malignancy; **AND**
        v. Active malignancy, except non-melanoma skin cancer; **AND**
        vi. History of thrombosis or thrombophilia; **AND**
        vii. A known hypersensitivity to mannitol; **AND**
    c. The individual has not previously received Roctavian or any other gene therapy; **AND**
    d. The individual has been counseled on the risks of alcohol consumption after receiving Roctavian and has been directed to abstain from alcohol consumption for at least 1 year following infusion, and to limit consumption thereafter; **AND**
    e. Treatment with Factor VIII products for prophylaxis will be stopped after Roctavian infusion achieves adequate Factor VIII levels; **AND**
    f. The treating provider will follow all FDA-approved labeling recommendations for usage, dosage, preparation, administration, monitoring and patient education.

Reauthorization Requests
N/A

Investigational and Not Medically Necessary
Roctavian is intended for one-time single-dose intravenous use only, repeat administration with Roctavian is considered investigational and not medically necessary.

Roctavian for any other indication is considered investigational and not medically necessary.

NOTE: EPSDT Special Provision
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b

(2011) [ref. CMAP Provider Bulletin PB 2011-36].

PROCEDURE
Prior authorization of Roctavian is required. Coverage determinations will be based upon a review of requested and/or submitted case-specific information.

The following information is needed to review requests for Roctavian:

1. Fully completed State of Connecticut, Department of Social Services HUSKY Health Program Roctavian Prior Authorization Request form (to include physician's order and signature);
2. Clinical documentation supporting the medical necessity of treatment with Roctavian should include the following:
    a. Medical record documentation confirming:
        i. Diagnosis of severe hemophilia A; **AND**
    b. Laboratory values confirming:
        i. Factor VIII levels ≤ 1 IU/dL; **AND**
        ii. Negative Factor VIII inhibitor test dated within the previous 30 days; **AND**
        iii. Absence of AAV5 antibodies; **AND**
        iv. Platelet count ≥ 10 x 10^9/L; **AND**
        v. Creatinine < 1.4 mg/dL; **AND**
    c. Signed provider attestation confirming the following:
        i. History of prophylactic Factor VIII use for at least 150 exposure days; **AND**
        ii. The individual is currently undergoing treatment with Factor VIII prophylaxis, however this will be stopped after Roctavian infusion achieves adequate Factor VIII levels; **AND**
        iii. The individual does not have any of the following:
            1. Active infections, either acute or uncontrolled chronic as defined in the above criteria; **AND**
            2. Immunosuppressive disorder; **AND**
            3. Significant liver disease as defined in the above criteria; **AND**
            4. Active malignancy, except non-melanoma skin cancer; **AND**
            5. History of thrombosis or thrombophilia; **AND**
            6. Hypersensitivity to mannitol; **AND**
        iv. The individual has not previously received Roctavian or any other gene therapy; **AND**
        v. The individual has been counseled on the risks of alcohol consumption after receiving Roctavian and has been directed to abstain from alcohol consumption for at least 1 year following infusion, and to limit consumption thereafter; **AND**
        vi. The individual will be monitored as recommended in the FDA-approved labeling; **AND**
3. Other information as requested.

Initial Authorization
If approved, authorization will be given for a one-time, single-dose intravenous infusion of Roctavian, per lifetime.

Reauthorization
N/A

EFFECTIVE DATE

This Policy for the prior authorization of Roctavian for individuals covered under the HUSKY Health Program is effective August 1,2025.

LIMITATIONS
N/A

CODE:

Code	Definition
J1412	Injection, valoctocogene roxaparvovec-rvox, per ml, containing nominal 2 x 1013 vector genomes

DEFINITIONS

1. **Current Procedural Terminology (CPT):** The most recent edition of a listing, published by the American Medical Association, of descriptive terms and identifying codes for reporting medical services performed by providers.
2. **HUSKY A**: Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
3. **HUSKY B**: Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children's Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
4. **HUSKY C**: Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.
5. **HUSKY D**: Connecticut residents who are ages 19-64 without dependent children and who: (1) do not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).
6. **HUSKY Health Program**: The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.
7. **HUSKY Limited Benefit Program or HUSKY, LBP**: Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.
8. **Medically Necessary or Medical Necessity**: (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B)recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.
9. **Prior Authorization**: A process for approving covered services prior to the delivery of the service

or initiation of the plan of care based on a determination by CHNCT as to whether the requested service is medically necessary.

ADDITIONAL RESOURCES AND REFERENCES:

- Gene Therapy Study in Severe Haemophilia A Patients (270-201). ClinicalTrials.gov identifier: NCT02576795. Updated April 10, 2025. Accessed May 30, 2025. https://www.clinicaltrials.gov/study/NCT02576795
- Mahlangu J, Kaczmarek R, von Drygalski A, et al. Two-Year Outcomes of Valoctocogene Roxaparvovec Therapy for Hemophilia A. *N Engl J Med*. 2023;388(8):694-705. doi:10.1056/NEJMoa2211075
- Malec L. Clinical manifestations and diagnosis of hemophilia A and B. *In: UpToDate.* Shapiro AD & Tirnauer JS (Eds). Wolters Kluwer. Updated May 15, 2025. Accessed May 30, 2025.
- Oldenburg J, Chambost H, Liu H, et al. Comparative Effectiveness of Valoctocogene Roxaparvovec and Prophylactic Factor VIII Replacement in Severe Hemophilia A. *Adv Ther.* 2024;41(6):2267-2281. doi:10.1007/s12325-024-02834-9
- Ozelo MC, Mahlangu J, Pasi KJ, et al. Valoctocogene Roxaparvovec Gene Therapy for Hemophilia A. *N Engl J Med*. 2022;386(11):1013-1025. doi:10.1056/NEJMoa2113708
- Pasi KJ, Rangarajan S, Mitchell N, et al. Multiyear Follow-up of AAV5-hFVIII-SQ Gene Therapy for Hemophilia A. *N Engl J Med*. 2020;382(1):29-40. doi:10.1056/NEJMoa1908490
- Roctavian [prescribing information]. Novato, CA. BioMarin Pharmaceutical Inc. Revised June 2023.
- Single-Arm Study To Evaluate The Efficacy and Safety of Valoctocogene Roxaparvovec in Hemophilia A Patients (BMN 270-301) (BMN 270-301). ClinicalTrials.gov identifier: NCT03370913. Updated March 25, 2025. Accessed May 30, 2025. https://clinicaltrials.gov/study/NCT03370913

PUBLICATION HISTORY

Status	Date	Action Taken
Original publication	May 2025	Approved at the June 11, 2025 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on June 16, 2025. Approved by DSS on July 9, 2025.