

## **Clinical Policy: Factor XIII A-Subunit, Recombinant (Tretten)**

Reference Number: CP.PHAR.222

Effective Date: 05.01.16

Last Review Date: 02.19

Line of Business: Medicaid, HIM-Medical Benefit

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Factor XIII A-subunit, recombinant (Tretten®) is a recombinant factor XIII concentrate.

### **FDA Approved Indication(s)**

Tretten is indicated for routine prophylaxis of bleeding in patients with congenital factor XIII A-subunit deficiency.

Limitation(s) of use: Tretten is not for use in patients with congenital factor XIII B-subunit 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<sup>®</sup> that Tretten is **medically necessary** when the following criteria are met:

#### **I. Initial Approval Criteria**

##### **A. Congenital Factor XIII A-Subunit Deficiency (must meet all):**

1. Diagnosis of congenital factor XIII A-subunit deficiency;
2. Prescribed by or in consultation with a hematologist;
3. Request is for routine prophylaxis to prevent or reduce the frequency of bleeding episodes.

**Approval duration: 6 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.PMN.53 for Medicaid and HIM-Medical Benefit.

#### **II. Continued Therapy**

##### **A. Congenital Factor XIII A-Subunit Deficiency (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.

**Approval duration: 6 months**

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#### 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 6 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.PMN.53 for Medicaid and HIM-Medical Benefit.

#### 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.PMN.53 for Medicaid and HIM-Medical Benefit 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): hypersensitivity to the active substance or to any of the excipients
- Boxed warning(s): none reported

#### V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Routine bleeding prophylaxis	35 IU/kg IV once monthly to achieve a target trough level of Factor XIII activity $\geq$ 10%.  Consider dose adjustment if adequate coverage is not achieved with the 35 IU/kg dose.	Individualized

#### VI. Product Availability

Powder for reconstitution in single-use vial: nominally 2,500 IU/vial (2,000 – 3,125 IU)

#### VII. References

1. Tretten Prescribing Information. Plainsboro, NJ: Novo Nordisk; November 2016. Available at <http://www.novo-pi.com/tretten.pdf>. Accessed November 8, 2018.
2. Srivastava A, Brewer AK, Mauser-Bunschoten EP, et al. Guidelines for the management of hemophilia. *Haemophilia*. Jan 2013; 19(1): e1-47.
3. Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation (NHF): Database of treatment guidelines. Available at <https://www.hemophilia.org/Researchers-Healthcare-Providers/Medical-and-Scientific-Advisory-Council-MASAC/MASAC-Recommendations>. Accessed September 26, 2018.

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**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.

HCPCS Codes	Description
J7181	Injection, factor XIII A-subunit, (recombinant), per IU

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.12 Blood Factors and converted to new template. Diagnosis is edited to XIII A-Subunit deficiency per PI; use is edited per PI to prophylactic use; approval period is edited to 6 months/6 months. Reviewed by specialist.	04.01.16	05.16
Safety information removed. Wording for uses, approval duration, and use of “congenital” versus “acquired” for describing hemophilias, made consistent across all blood factor policies. Efficacy statement added to renewal criteria. Reviewed by specialist- hematology/internal medicine.	04.01.17	05.17
1Q18 annual review: - No significant changes - Converted to new template - Referenced 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

**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

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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.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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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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