Reference number(s)
4035-A

JURISDICTION SPECIFIC MEDICARE PART B

OBIZUR (antihemophilic factor [recombinant], porcine sequence)

POLICY

I. COVERED USES

The indications below are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

Obizur is indicated for the on-demand treatment and control of bleeding episodes in adults with acquired hemophilia A

All other indications will be assessed on an individual basis. Submissions for indications other than those enumerated in this policy should be accompanied by supporting evidence from Medicare approved compendia.

II. DOCUMENTATION

The following documentation must be available in a legible format with patient identification information (e.g., complete name and dates of service) and signature of physician or non-physician practitioner responsible for and providing care to the member, upon request, for all submissions:

A. The submitted medical record must support the use of the selected ICD-10-CM codes. The submitted CPT/HCPCS code must describe the service performed.
B. The medical record documentation must support the medical necessity of the services as stated in this policy.

III. CRITERIA FOR APPROVAL

Acquired hemophilia A
Authorization of 12 months may be granted for treatment of acquired hemophilia A.

IV. REFERENCES

1. Hemophilia Factor Products LCD (L35111) Version R16. Available at: https://www.cms.gov/medicare-coverage-database/indexes/national-and-local-indexes.aspx. Accessed December 15, 2021.
2. Billing and Coding: Hemophilia Factor Products (A56433) Version R7. Available at: https://www.cms.gov/medicare-coverage-database/indexes/national-and-local-indexes.aspx. Accessed December 15, 2021.
3. Obizur [package insert]. Lexington, MA: Baxalta US, Inc.; September 2021.

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