



Drug Coverage Policy

Effective Date10/9/2025

Coverage Policy Number.....IP0580

Policy Title..... Roctavian

Hemophilia – Gene Therapy – Roctavian

- Roctavian® (valoctocogene roxaparvovec-rvox intravenous infusion – BioMarin)

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

OVERVIEW

Roctavian, an adeno-associated virus vector-based gene therapy, is indicated for the treatment of severe hemophilia A (congenital Factor VIII deficiency with Factor VIII activity < 1 IU/dL) in adults

without pre-existing antibodies to adeno-associated virus serotype 5 detected by an FDA-approved test.¹

Disease Overview

Hemophilia A is an X-linked bleeding disorder primarily impacting males caused by a deficiency in Factor VIII.^{2,3} The incidence of hemophilia A in males is 1:5,000 livebirths.² The condition is characterized by prolonged bleeding after injuries, as well as spontaneous bleeds. Bleeding can occur in many different body areas as well (e.g., muscles, central nervous system, joints). The bleeding manifestations can lead to substantial morbidity such as hemophilic arthropathy.^{2,3} Disease severity is usually defined by the plasma levels or activity of Factor VIII classified as follows: severe (< 1%), moderate (1% to 5%), and mild (> 5% to < 40%); phenotypic expression may vary.³ The management of hemophilia involves use of agents to treat bleeding episodes, therapies given prophylactically to prevent bleeding, and gene therapy.^{2,3}

Clinical Efficacy

The efficacy of Roctavian was evaluated in one open-label, single-group, multinational Phase III trial (GENEr8-1) involving 134 adult males (≥ 18 years of age) with severe hemophilia A (Factor VIII activity level ≤ 1 IU/dL).^{1,4,5} Patients involved in the trial did not have Factor VIII inhibitors (or a history of such inhibitors) and were receiving regular prophylaxis with Factor VIII products.⁴ Use of prophylactic Factor VIII therapy was not permitted during the trial, but could be used up to 4 weeks post Roctavian administration to allow the agent to have an effect.⁴ Other notable exclusion criteria were active infection, chronic or active hepatitis B or C, immunosuppressive disorder (including human immunodeficiency virus [HIV]), Stage 3 or 4 liver fibrosis, cirrhosis, liver function test abnormalities, serum creatinine ≥ 1.4 mg/dL, and active malignancy.¹ Patients had to be treated or exposed to Factor VIII concentrates previously for a minimum of 150 exposure days.⁴ Among 132 patients (who were HIV-negative), the mean Factor VIII activity level at Weeks 49 through 52 had increased by 41.9 IU/dL.⁴ Among the 112 patients enrolled from the noninterventional study, the mean annualized rates of Factor VIII concentrate use and treated bleeding after Week 4 had decreased after Roctavian administration by 98.6% and 83.8%, respectively ($P < 0.001$ for both comparisons).^{4,5} At a median of 3 years post Roctavian dosing, the mean annualized bleeding rate in the rollover population ($n = 112$) in the efficacy evaluation period was 2.6 bleeds/year compared to a mean baseline of 5.4 bleeds/year (while using Factor VIII therapies).¹ Long-term data (up to 4 years) reports favorable results with Roctavian.⁵⁻⁷

Coverage Policy

POLICY STATEMENT

Prior Authorization is recommended for benefit coverage of Roctavian. Approval is recommended for those who meet the **Criteria** and **Dosing** for the listed indication. Because of the specialized skills required for evaluation and diagnosis of patients treated with Roctavian as well as the monitoring required for adverse events and long-term efficacy, approval requires Roctavian to be prescribed by a physician who specializes in the condition being treated. All approvals are provided for one time (per lifetime) as a single dose. If claims history is available, verification is required for certain criteria as noted by **[verification in claims history required]**. For the dosing criteria, verification of the appropriate weight-based dosing is required by a Medical Director as noted by **[verification required]**. In the criteria for Roctavian, as appropriate, an asterisk (*) is noted next to the specified gender. In this context, the specified gender is defined as follows: males are defined as individuals with the biological traits of a man, regardless of the individual's gender identity or gender expression. All reviews (approvals and denials) will be forwarded to the Medical Director for evaluation.

Documentation: Documentation is required for use of Roctavian as noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to chart notes,

laboratory results, medical test results, claims records, prescription receipts, and/or other information.

Roctavian is considered medically necessary when the following criteria are met:

FDA-Approved Indication

- 1. Hemophilia A.** Approve a one-time (per lifetime) single dose if the patient meets ALL of the following (A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, and S):
 - A)** Patient is male*; AND
 - B)** Patient is ≥ 18 years of age; AND
 - C)** Patient has not received Roctavian in the past **[verification in claims history required]**; AND
Note: If no claim for Roctavian is present (or if claims history is not available), the prescribing physician confirms that the patient has not previously received Roctavian.
 - D)** Patient has severe hemophilia A as evidence by a baseline (without Factor VIII replacement therapy) Factor VIII level of < 1 IU/dL **[documentation required]**; AND
 - E)** Patient does not have detectable pre-existing antibodies to adeno-associated virus 5 (AAV5) by an FDA-approved test **[documentation required]**; AND
 - F)** According to the prescribing physician, the patient has a history of use of Factor VIII therapy for at least 150 exposure days; AND
 - G)** Patient meets ALL of the following (i, ii, and iii):
 - i.** Factor VIII inhibitor titer testing has been performed within the past 30 days **[documentation required]**; AND
 - ii.** Patient does not currently have an inhibitor to Factor VIII **[documentation required]**; AND
 - iii.** Patient does not have a history of Factor VIII inhibitors **[documentation required]**; AND
 - H)** Prophylactic therapy with Factor VIII will not be given after Roctavian administration once adequate Factor VIII levels have been achieved; AND
Note: Use of episodic Factor VIII therapy is acceptable for the treatment of bleeds and for surgery/procedures if needed as determined by the hemophilia specialist physician.
 - I)** Patient does not have a known hypersensitivity to mannitol; AND
 - J)** Patient does not have chronic or active hepatitis B **[documentation required]**; AND
 - K)** Patient does not have active hepatitis C **[documentation required]**; AND
 - L)** Patient is not human immunodeficiency virus positive **[documentation required]**; AND
 - M)** Patient does not have evidence of significant hepatic fibrosis or cirrhosis; AND
 - N)** Patient meets ONE of the following (i or ii):
 - i.** Patient has undergone liver function testing within the past 30 days and meets ALL of the following (a, b, c, d, e, and f):
 - a)** Alanine aminotransferase levels are ≤ 1.25 times the upper limit of normal **[documentation required]**; AND
 - b)** Aspartate aminotransferase levels are ≤ 1.25 times the upper limit of normal **[documentation required]**; AND
 - c)** Total bilirubin levels are ≤ 1.25 times the upper limit of normal **[documentation required]**; AND
 - d)** Alkaline phosphatase levels are ≤ 1.25 times the upper limit of normal **[documentation required]**; AND
 - e)** Gamma-glutamyl transferase levels are ≤ 1.25 times the upper limit of normal **[documentation required]**; AND
 - f)** The International Normalized Ratio is < 1.4 **[documentation required]**; OR
 - ii.** If the patient had one or more of the laboratory values listed in *Criteria a-f* above that was not at the value specified in *Criteria a-f* above, then a hepatologist has evaluated the patient and has determined that use of Roctavian is clinically appropriate **[documentation required]**; AND

- O)** Within the past 30 days, the platelet count was $\geq 100 \times 10^9/L$ **[documentation required]**; AND
- P)** Within the past 30 days, the creatinine level was $< 1.4 \text{ mg/dL}$ **[documentation required]**; AND
- Q)** Medication is prescribed by a hemophilia specialist physician; AND
- R)** Current patient body weight has been obtained within the past 30 days **[documentation required]**; AND
- S)** If criteria A through R are met, approve one dose of Roctavian to provide for a one-time (per lifetime) single dose of 6×10^{13} vector genomes per kg by intravenous infusion **[verification required]**.

Note: Roctavian is supplied in a carton (NDC 68135-927-48) that contains one single dose vial (NDC 68135-927-01) with an extractable volume of not less than 8 mL, containing 16×10^{13} vector genomes.

* Refer to the Policy Statement.

Dosing. The recommended dose of Roctavian is a one-time (per lifetime) single dose of 6×10^{13} vector genomes per kg based on body weight in kg by intravenous infusion.

Conditions Not Covered

Any other use is considered experimental, investigational, or unproven, including the following (this list may not be all inclusive; criteria will be updated as newly published data are available):

- 1. Prior Receipt of Gene Therapy.** Prior receipt of gene therapy was a reason for patient exclusion in the pivotal study.

Coding Information

- Note:** 1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

HCPCS Codes	Description
J1412	Injection, valoctocogene roxaparvovec-rvox, per ml, containing nominal 2×10^{13} vector genomes

References

1. Roctavian® intravenous infusion [prescribing information]. Novato, CA: BioMarin; June 2023.
2. Chowdary P, Carcao M, Kenet G, Pipe W. Haemophilia. *Lancet*. 2025;405:736-750.
3. Konkle BA, Nakaya Fletcher S. Hemophilia A. 2000 Sep 21 [updated 2025 Aug 7]. In: Adam MP, Feldman J, Mirzaa GM, Pagon RA, Wallace SE, Amemiya A, editors. GeneReviews® [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2025. PMID: 20301578.
4. Ozelo MC, Mahlangu J, Pasi KJ, et al, for the GENE8-1 trial group. Valoctocogene roxaparvovec gene therapy for hemophilia A. *N Engl J Med*. 2022;386(11):1013-1025.
5. Mahlangu J, Kaczmarek R, Von Drygalski A, et al, for the GENE8-1 trial group. Two-year outcomes of valoctocogene roxaparvovec therapy for hemophilia A. *N Engl J Med*. 2023;388(8):694-705.

6. Madan B, Ozelo MC, Paheja P, et al. Three-year outcomes of valoctocogene roxaparvovec gene therapy for hemophilia A. *J Thromb Haemost*. 2024;22:1880-1893.
7. Leavitt AD, Mahlangu J, Raheja P, et al. Efficacy, safety, and quality of life 4 years after valoctocogene roxaparvovec gene transfer for severe hemophilia A in the phase 3 GENEr8-1 trial. *Res Pract Thromb Haemost*. 2024;8:e102615.

Revision Details

Type of Revision	Summary of Changes	Date
New	New Policy	9/26/2023
Annual Revision	Policy Title: Updated from "Valoctocogene roxaparvovec-rvox" to "Hemophilia – Gene Therapy – Roctavian." Added "Policy Statement" to the policy. Added "Documentation: Documentation is required for use of Roctavian as noted in the criteria as [documentation required]. Documentation may include, but is not limited to chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information." Hemophilia A: • Added for approval, "Approve a one-time (per lifetime) single dose if the patient meets ALL of the following:." • Added "verification in claims history required" for criteria which addresses that the patient has not received Roctavian in the past and added "Note: If no claim for Roctavian is present (or if claims history is not available), the prescribing physician confirms that the patient has not previously received Roctavian." • Updated criterion from "Documentation showing negative for human immunodeficiency virus" to "Patient is not human immunodeficiency virus positive [documentation required]." • The phrase "according to the prescribing physician" was added to the requirement that the patient has a history of use of Factor VIII therapy for at least 150 exposure days. • The phrase "within 30 days before the intended receipt of Roctavian" was replaced with "within the past 30 days" regarding the requirement that Factor VIII inhibitor titer testing has been performed. • The requirement was removed that the patient does not have an active acute or uncontrolled chronic infection. • The phrase "liver health assessment" was replaced with "liver function testing." Also, the phrase "within 30 days before the intended receipt of	10/10/2024

	Roctavian" was replaced with "within the past 30 days" regarding the liver function testing. • The phrase, "within 30 days before the intended receipt of Roctavian" was replaced with "within the past 30 days" regarding the requirement that the platelet count was $\geq 100 \times 10^9/L$. • The phrase "within 30 days before the intended receipt of Roctavian" was replaced with "within the past 30 days" regarding the requirement that the creatinine level was $< 1.4 \text{ mg/dL}$. • The requirement (along with the related Note) was removed that the patient has not used a systemic immunosuppressive agent within 30 days before intended receipt of Roctavian. • The requirement was removed that the patient does not have any disease or condition that would interfere with the compliance requirements that involve use of systemic corticosteroid therapy or systemic alternative immunosuppressive medications. • The requirement was removed that the patient does not have an immunosuppressive disorder. • The requirement was removed that the patient does not have any additional bleeding disorder, besides hemophilia A. • The requirement was removed that the patient does not have a history of thrombosis or thrombophilia. • The requirement (along with the related Note) was removed that the patient does not have a current active malignancy. • The requirement was removed that the patient does not have a history of hepatic malignancy. • The requirement was removed that the patient has not received a live vaccine within 30 days before intended receipt of Roctavian. • The requirement was removed that the hemophilia specialist physician has discussed with the patient that for a period of up to 6 months after administration of Roctavian that precautions should be taken that a male of reproductive potential (and his female partner) prevent or postpone pregnancy by utilizing an effective form of contraception and that a male should not donate semen. • The phrase "within 30 days before the intended receipt of Roctavian" was replaced with "within the past 30 days" regarding the requirement that current patient body weight has been obtained. Conditions Not Recommended for Approval: The condition of "Prior Receipt of Gene Therapy" was added.	
Annual Revision	No criteria changes.	10/9/2025

The policy effective date is in force until updated or retired.

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