

Hyftor (crizanlizumab-tcma)
Effective 02/01/2023

Plan	<input type="checkbox"/> MassHealth UPPL <input checked="" type="checkbox"/> Commercial/Exchange	Program Type	<input checked="" type="checkbox"/> Prior Authorization <input type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
Benefit	<input checked="" type="checkbox"/> Pharmacy Benefit <input type="checkbox"/> Medical Benefit		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	Medical Benefit Pharmacy Benefit	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029
Exceptions	N/A		

Overview

Hyftor is indicated for the treatment of facial angiofibroma associated with tuberous sclerosis in adults and pediatric patients 6 years of age and older.

Coverage Guidelines

Authorization may be granted for members new to the plan who are currently receiving treatment with Hyftor, excluding when the product is obtained as samples or via manufacturer's patient assistance programs

OR

Authorization may be granted if the member meets all following criteria and documentation has been submitted:

1. The member has a diagnosis of facial angiofibroma associated with tuberous sclerosis
2. The member is \geq 6 years of age.

Continuation of Therapy

Reauthorization may be granted for members who have met the initial criteria and the physician has submitted clinical documentation of clinical response.

Limitations

1. Initial approvals will be granted for 3 months
2. Reauthorization may be granted for 6 months

References

1. Hyftor (sirolimus topical) [prescribing information]. Bethesda, MD: Nobelpharma America LLC; March 2022.

Review History

01/11/2023 – Created and Reviewed for January P&T. Effective 02/01/23