

**Thrombocytopenic Agents**  
**Cablivi (caplicizumab-yhdp)**  
**Effective 05/12/2025**

Plan	<input checked="" type="checkbox"/> MassHealth <input type="checkbox"/> Commercial/Exchange	Program Type	<input checked="" type="checkbox"/> Prior Authorization <input type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
Benefit	<input type="checkbox"/> Pharmacy Benefit <input checked="" type="checkbox"/> Medical Benefit		
Specialty Limitations	N/A		
Contact Information	Medical and Specialty Medications		
	All Plans	Phone: 877-519-1908	Fax: 855-540-3693
Contact Information	Non-Specialty Medications		
	All Plans	Phone: 800-711-4555	Fax: 844-403-1029
Notes	Cablivi is also available on the pharmacy benefit. Please see the <a href="#">MassHealth Drug List</a> for coverage and criteria.  Additional agents from this class are available through the pharmacy benefit. Please see the <a href="#">MassHealth Drug List</a> for coverage and criteria.		

### Overview

Cablivi is indicated for the treatment of adult patients with acquired thrombotic thrombocytopenic purpura (aTTP), in combination with plasma exchange and immunosuppressive therapy.

### Coverage Guidelines

Authorization may be reviewed on a case by case basis for members who are new to the plan currently receiving treatment with requested medication excluding when the product is obtained as samples or via manufacturer's patient assistance programs.

### OR

Authorization may be granted for members when all the following criteria are met, and documentation is provided:

1. The member has a diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP)
2. The requested medication will be given in combination with immunosuppressive therapy (e.g., corticosteroids, rituximab)
3. Member is  $\geq 18$  years of age
4. Requested quantity is  $\leq 1$  unit/day after initial bolus injection

### Continuation of Therapy

Reauthorizations require prescriber documentation that members have sign(s) of persistent underlying disease such as suppressed ADAMTS13 activity levels following the initial 30 days of treatment.

### Limitations

1. Initial approvals are limited to 30 days of therapy
2. Reauthorizations are limited to 28 days of therapy. May only approve **up to a max of 28 additional days**.

## References

1. Cablivi [package insert]. Cambridge, MA: Genzyme Corporation; February 2019.
2. Scully M, Cataland SR, Peyvandi F; et al. Caplacizumab treatment for acquired thrombotic thrombocytopenic purpura. *N Engl J Med*. 2019;380(4):335-346.
3. Sadler JE. Pathophysiology of thrombotic thrombocytopenic purpura. *Blood*. 2017;130(10):1181-1188.
4. Scully M, Cataland S, Coppo P, et al. Consensus on the standardization of terminology in thrombotic thrombocytopenic purpura and related thrombotic microangiopathies. *J Thromb Haemost*. 2017;15(2):312-322.
5. Scully M, Hunt BJ, Benjamin S, et al. Guidelines on the diagnosis and management of thrombotic thrombocytopenic purpura and other thrombotic microangiopathies. *Br J Haematol*. 2012;158(3):323-335.
6. Westwood JP, Thomas M, Alwan F, et al. Rituximab prophylaxis to prevent thrombotic thrombocytopenic purpura relapse: outcome and evaluation of dosing regimens. *Blood Adv*. 2017;1(15):1159-1166.

## Review History

09/22/2021 – Reviewed at Sept P&T; no clinical changes; separated out MH vs. Comm/Exch. Effective 01/01/2022

03/15/23 - Reviewed and updated for Mar P&T. Matched MH UPPL criteria. Removed requirement of prescriber specialty. Added quantity limit to criteria. Simplified reauth criteria. Effective 4/1/23.

10/9/24 – Reviewed and updated for P&T. Formatting updates. No clinical changes. Effective 11/12/24

04/09/25 – Reviewed and updated for P&T. Reauthorization verbiage was updated to state "up to a max of 28 days" following FDA label. Effective 05/12/25

