

| Field Name                            | Field Description  |
|---------------------------------------|--|
| Prior Authorization Group Description | <b>Adzynma</b>   |
| Drugs                                 | Adzynma (ADAMTS13, recombinant-krhn)   |
| Covered Uses                          | Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.  |
| Exclusion Criteria                    | N/A  |
| Required Medical Information          | See “other criteria”   |
| Age Restrictions                      | According to package insert  |
| Prescriber Restrictions               | Prescriber must be a hematologist, oncologist, intensive care specialist, or specialist in the treatment of rare genetic hematologic diseases  |
| Coverage Duration                     | <p><u>On-demand therapy:</u> If all criteria are met, the request will be approved for 1 month.</p> <p><u>Prophylactic therapy:</u> If all criteria are met, the initial request will be approved for 6 months. Reauthorization requests will be approved for 12 months.</p>   |
| Other Criteria                        | <p><b><u>Initial Authorization</u></b></p> <ul style="list-style-type: none"> <li>• Diagnosis of congenital thrombotic thrombocytopenic purpura (cTTP) as confirmed by BOTH of the following: <ul style="list-style-type: none"> <li>○ Molecular genetic testing</li> <li>○ ADAMTS13 activity &lt;10%</li> </ul> </li> <li>• Prescriber attestation that member has not been diagnosed with any other TTP-like disorder (i.e., microangiopathic hemolytic anemia, immune-mediated thrombotic thrombocytopenic purpura [iTTP])</li> <li>• If request is for prophylactic therapy, member must also have a history of at least one documented TTP event</li> <li>• Member’s weight</li> <li>• Request is for an FDA-approved dose</li> </ul> <p><b><u>Reauthorization</u></b></p> <ul style="list-style-type: none"> <li>• Documentation of positive clinical response to therapy (i.e., improvement in acute and subacute TTP events, platelet counts, microangiopathic hemolytic anemia episodes, or clinical symptoms)</li> <li>• Member’s weight</li> <li>• Request is for an FDA-approved dose</li> </ul> |

Revision/Review  
Date: 4/2025

**Medical Director/clinical reviewer may override criteria when, in his/her professional judgement, the requested item is medically necessary.**

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