Pharmacy Medical Necessity Guidelines: Medications for the Treatment of Hepatitis C

Effective: July 15, 2019

Prior Authorization Required | ✓ | Type of Review – Care Management | ✓ | Type of Review – Clinical Review |
Not Covered | | Pharmacy (RX) or Medical (MED) Benefit | RX | Department to Review |

This pharmacy medical necessity guideline applies to the following:

**Tufts Health Plan Commercial Plans**
- Tufts Health Plan Commercial Plans – large group plans
- Tufts Health Plan Commercial Plans – small group and individual plans

**Tufts Health Public Plans**
- Tufts Health Direct – Health Connector
- Tufts Health Together – A MassHealth Plan
- Tufts Health RITogether – A Rite Care + Rhody Health Partners Plan

**Tufts Health Freedom Plan products**
- Tufts Health Freedom Plan - large group plans
- Tufts Health Freedom Plan - small group plans

**Fax Numbers:**
RXUM: 617-673-0988

**OVERVIEW**

**FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS**

Hepatitis C medications covered on the formulary are included in the table below. All medications require prior authorization. See information in the Limitations section for more details. Requests for non-covered Hepatitis C medications will be reviewed with the Non-Covered with Suggested Alternatives Medical Necessity Guideline.

Epclusa (sofosbuvir/velpatasvir), Harvoni (ledipasvir/sofosbuvir), Mavyret (glecaprevir/pibrentasvir) and Vosevi (sofosbuvir/velpatasvir/voxilaprevir) are the preferred medications for the treatment of hepatitis C. The following is a general guide to when a step through preferred product(s) applies within the coverage criteria:

- Epclusa (sofosbuvir/velpatasvir), Harvoni (ledipasvir/sofosbuvir) eight week, and Mavyret (glecaprevir/pibrentasvir) eight week regimens are at parity and do not require a step through another medication for the treatment of hepatitis C when all other coverage criteria are met.
- Most requests for other regimens must provide a clinical rationale for use of a non-preferred regimen instead of on or more preferred regimens.

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<thead>
<tr>
<th>Drug</th>
<th>FDA-Approved Indication</th>
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<tr>
<td><strong>Preferred Products</strong></td>
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<tr>
<td><strong>Epclusa</strong> (sofosbuvir/velpatasvir)</td>
<td>Adults with chronic HCV genotype 1-6 infection without cirrhosis or with cirrhosis (compensated or decompensated)</td>
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| **Harvoni** (ledipasvir/sofosbuvir) | • Adults with chronic HCV infection  
  o Genotype 1, 4, 5, or 6 without cirrhosis or with compensated cirrhosis  
  o Genotype 1 with decompensated cirrhosis  
  o Genotype 1 or 4 who are liver transplant recipients without cirrhosis or with compensated cirrhosis  
  • Pediatrics with chronic HCV infection  
  o Genotype 1, 4, 5, or 6 without cirrhosis or with compensated cirrhosis |
| **Mavyret** (glecaprevir/pibrentasvir) | • Adults and pediatric patients (12 years and older or weighing at least 45 kg) with chronic HCV infection genotype 1, 2, 3, 4, 5, or 6 without cirrhosis and with compensated cirrhosis  
  • Adults and pediatric patients (12 years and older or weighing at least 45 kg) with chronic HCV infection genotype 1 infection, who previously have been treated with a regimen containing an HCV NS5A inhibitor or an NS3/4A protease inhibitor, but not both |
| **Vosevi** (sofosbuvir/velpatasvir/voxilaprevir) | • Adult patients with chronic HCV infection without cirrhosis or with compensated cirrhosis who have:  
  o Genotype 1-6 infection and have previously been treated with an HCV regimen containing an NS5A inhibitor |
<table>
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<th>Drug</th>
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<tr>
<td></td>
<td>o Genotype 1a or 3 infection and have previously been treated with an HCV regimen containing sofosbuvir without an NS5A inhibitor</td>
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<tr>
<td><strong>Non-preferred</strong></td>
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<tr>
<td>Daklinza (daclatasvir)</td>
<td>Adult patients with chronic HCV genotype 1 or 3 infection in combination with sofosbuvir, with or without ribavirin</td>
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| Sovaldi (sofosbuvir)  | 1. Adult patients with genotype 1, 2, 3, or 4 chronic HCV infection without cirrhosis or with compensated cirrhosis as a component of a combination antiviral treatment regimen.  
2. Pediatric patients 12 years of age and older or weighing at least 35 kg with genotype 2 or 3 chronic HCV infection without cirrhosis or with compensated cirrhosis in combination with ribavirin |
| Zepatier (elbasvir/ grazoprevir) | Adults patients with genotype 1 and 4 chronic HCV infection                                                                                                                                                                                                                                                                                       |

HCV=hepatitis C virus, FDA=Food and Drug Administration, RBV=ribavirin  
Compensated cirrhosis is defined as Child-Pugh A.  
Decompensated cirrhosis is defined as Child-Pugh B or C.

All patients should be tested for evidence of current or prior hepatitis B virus (HBV) infection before initiating treatment hepatitis C medications. HBV reactivation has been reported in HCV/HBV coinfected patients who were undergoing or had completed treatment with HCV direct acting antivirals and were not receiving HBV antiviral therapy. Some cases have resulted in fulminant hepatitis, hepatic failure, and death. Monitor HCV/HBV coinfected patients for hepatitis flare or HBV reactivation during HCV treatment and post-treatment follow-up. Initiate appropriate patient management for HBV infection as clinically indicated.

**COVERAGE GUIDELINES**
Tufts Health Plan may authorize coverage of Daklinza, Epclusa, Harvoni, Mavyret, Sovaldi, Vosevi, or Zepatier when all of the following criteria are met:

**REQUIRED DOCUMENTATION FOR ALL REQUESTS**
1. Documented diagnosis of chronic hepatitis C with confirmation of genotype  
   **AND**
2. Documentation of at least one of the following:  
   a. Member is at least 18 years of age if the request is for Daklinza, Epclusa, Mavyret, Sovaldi, Vosevi, or Zepatier  
   b. Member is at least 12 years of age if the request is for Harvoni  
   c. Member is at least 12 years of age or weighing at least 45 kg for Mavyret  
   **AND**
3. Documentation of stage of hepatic fibrosis (e.g., F0-F4) through one of the following:  
   a. Liver biopsy confirming a METAVIR score or alternative scoring equivalent*  
   b. Transient elastography (Fibroscan) score  
   c. Fibrotest (FibroSURE) score  
   d. APRI score  
   e. Radiologic imaging  
   f. Physical findings or clinical evidence consistent with cirrhosis as attested by the prescribing physician  
   **AND**
4. Documentation of the presence or absence of cirrhosis

**Epclusa**
*Treatment-naïve and treatment-experienced (Members who have failed any regimen that does not contain an HCV NS5A inhibitor)*
1. Documentation of genotype 1, 2, 3, 4, 5, or 6  
   **AND**
2. Documentation the Member has not received previous treatment with an NS5A inhibitor containing regimen

Approval duration:  
• 12 weeks
Harvoni

Treatment-naïve genotype 1
1. Documentation of genotype 1
2. Documentation the Member is treatment naïve
3. Documentation of one of the following:
   a. Member is ≥12 and <18 years
   b. Member is ≥18 years AND no cirrhosis AND baseline viral load <6 million IU/mL
   c. Member is ≥18 years AND cirrhosis AND clinical rationale for use instead of Epclusa

Approval duration:
- Member ≥18 years, has no cirrhosis and a baseline viral load <6 million IU/mL: 8 weeks unless documentation of HIV co-infection, African American, presence of IL28B polymorphism CT or TT which will all be authorized for 12 weeks
- Member ≥18 years and has cirrhosis: 12 weeks
- Member is ≥12 and <18 years: 12 weeks

Note: Baseline viral load required within the last six month from date of coverage request

Treatment-naïve genotype 4-6
1. Documentation of genotype 4, 5, or 6
2. Documentation the Member is treatment naïve
3. Documentation of one of the following:
   a. Documentation Member is ≥12 and <18 years and requested duration is 12 weeks
   b. Documentation Member is ≥18 AND clinical rationale for use instead of Epclusa

Approval duration:
- 12 weeks

Treatment-experienced (Members who have failed any regimen that does not contain an HCV NS5A inhibitor)
1. Documentation of genotype 1, 4, 5, or 6
2. Documentation the Member has not received previous treatment with an NS5A inhibitor containing regimen
3. Documentation of one of the following:
   a. Documentation Member is ≥12 and <18 years
   b. Documentation Member is ≥18 years AND clinical rationale for use instead of Epclusa

Approval duration:
- 12 weeks
- Requests for 24 weeks duration require documentation of clinical inappropriateness of 12 weeks of Harvoni

Mavyret

Treatment-naïve
1. Documentation of genotype 1, 2, 3, 4, 5, or 6
2. Documentation the Member is treatment naïve
3. Documentation the Member is without decompensated cirrhosis
4. Documentation of one of the following:
   a. Member has no cirrhosis AND requested duration is for 8 weeks
   b. Member has compensated cirrhosis AND genotype 2 or 3 infection AND clinical rationale for use instead of Epclusa
   c. Member has compensated cirrhosis AND genotype 1, 4, 5, or 6 infection AND clinical rationale for use instead of Epclusa and Harvoni

Approval duration:
- Mavyret in treatment-naive patients without cirrhosis: 8 weeks
- Mavyret in treatment-naive patients with compensated cirrhosis: 12 weeks

**Previous Treatment with Interferon/Pegylated interferon and Ribavirin**

1. Documentation of genotype 1, 2, 3, 4, 5, or 6 AND
2. Documentation the Member has received previous therapy with interferon/pegylated interferon and ribavirin AND
3. Documentation the Member is without decompensated cirrhosis AND
4. Documentation of one of the following:
   a. Genotype 1, 2, 4, 5, or 6 AND no cirrhosis
   b. Genotype 2 AND compensated cirrhosis AND clinical rationale for use instead of Epclusa
   c. Genotype 3 AND clinical rationale for use instead of Epclusa
   d. Genotype 1, 4, 5, or 6 AND compensated cirrhosis AND clinical rationale for use instead of Epclusa AND Harvoni

Approval duration:
- Genotypes 1-6 without cirrhosis: 8 weeks
- Genotype 1, 2, 4, 5, or 6 with compensated cirrhosis: 12 weeks
- Genotype 3: 16 weeks

**Previous Treatment with a Protease Inhibitor and Pegylated Interferon and Ribavirin**

1. Documentation of genotype 1 AND
2. Documentation the Member has received previous therapy pegylated interferon and ribavirin with or without a protease inhibitor AND
3. Documentation the Member is without decompensated cirrhosis AND
4. Clinical rationale for use instead of Epclusa and Harvoni

Approval duration:
- 12 weeks

**Previous Treatment with Sovaldi/Olysio**

1. Documentation of genotype 1 AND
2. Documentation the Member has received previous therapy with Sovaldi and Olysio AND
3. Documentation the Member is without decompensated cirrhosis AND
4. Documentation of one of the following:
   a. Genotype 1a
   b. Genotype 1b AND clinical rationale for use instead of Epclusa

Approval duration:
- Mavyret will be approved for 12 weeks

**Previous Treatment with Sovaldi/pegylated interferon/ribavirin or Sovaldi/ribavirin**

1. Documentation of genotype 1, 2, 3, 4, 5, or 6 AND
2. Documentation the Member has received previous treatment with Sovaldi/PEG/RBV or Sovaldi/RBV AND
3. Documentation the Member is without decompensated cirrhosis AND
4. Documentation of one of the following
   a. Genotype 1, 2, 4, 5, or 6 AND no cirrhosis
   b. Genotype 3
   c. Genotype 1a, 4, 5, or 6 AND compensated cirrhosis
   d. Genotype 1b or 2 AND compensated cirrhosis AND clinical rationale for use instead of Epclusa

Approval duration
- Genotypes 1, 2, 4, 5, or 6 and no cirrhosis: 8 weeks
- Genotype 3: 16 weeks
- Genotype 1, 2, 4, 5, or 6 and compensated cirrhosis: 12 weeks

**HCV NS5A Inhibitor Treatment-experienced**
1. Documentation of genotype 1 AND
2. Documentation the Member has previously received an NS5A inhibitor containing regimen AND
3. Documentation the Member is without decompensated cirrhosis

Approval duration
- 16 weeks

**Vosevi**

**HCV NS5A Inhibitor Treatment-experienced**
1. Documentation of genotype 1, 2, 3, 4, 5, or 6 AND
2. Documentation the Member has previously received an NS5A inhibitor containing regimen AND
3. Documentation the Member is without decompensated cirrhosis

Approval duration
- 12 weeks

**Previous treatment with a Sovaldi-containing regimen**
1. Documentation of genotype 1a or 3 AND
2. Documentation the Member has previously received therapy with a Sovaldi-containing regimen AND
3. Documentation the Member is without decompensated cirrhosis

Approval duration
- 12 weeks

**Daklinza**
1. Documentation of genotype 3 AND
2. Documentation of use in combination with Sovaldi AND
3. Clinical rationale for use instead of Epclusa and Mavyret

Approval duration
- 12 weeks
Sovaldi
1. Documentation of genotype 3
2. Documentation of one of the following: AND
   a. Documentation of no cirrhosis AND use in combination with Daklinza
   b. Documentation of compensated cirrhosis
3. Clinical rationale for use instead of Epclusa

Approval duration
- In combination with Daklinza: 12 weeks
- Monotherapy: 24 weeks

Zepatier
1. Documentation of genotype 1a, 1b, or 4 AND
2. Documentation the Member is without decompensated cirrhosis AND
3. Clinical rationale for use instead of Epclusa, Harvoni and Mavyret AND
4. If genotype 1a, documentation of results of NS5A polymorphism testing

Approval duration
- Genotype 1a treatment-naive or treatment experienced with pegylated interferon/ribavirin
  o Without baseline NS5A polymorphisms: 12 weeks
  o With baseline NS5A polymorphisms: 16 weeks
- Genotype 1b: 12 weeks
- Genotype 4 treatment-naive: 12 weeks
- Genotype 4 treatment-experienced: 16 weeks

*Comparison of Scoring Systems for Histological Stage (Fibrosis)*

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<th>METAVIR</th>
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**LIMITATIONS**
1. Vosevi will not be authorized for initial treatment.
2. Any alternative treatment requests will require detailed clinical documentation of need for alternative treatment and will be considered on a case by case basis.

**CODES**
None

**REFERENCES**
5. Mavyret (glecaprevir/pibrentasvir) [prescribing information]. North Chicago, IL; AbbVie Inc.; June 2019.

**APPROVAL HISTORY**
February 13, 2017: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:
- March 13, 2018: Updated duration of approval for Harvoni in treatment-naïve patients with genotype 1 infection to allow for 12 weeks for special populations (pediatric patients, HIV co-infection, African Americans, and IL28B polymorphism CT or TT). Updated Harvoni treatment-naïve genotype type 1 infection criteria to clarify that Members with cirrhosis must try and fail Epclusa.
- July 9, 2019: Updated indication for Mavyret to include pediatric patients age 12 and older or weighing at least 45 kg.

**BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION**
Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They are used in conjunction with a member’s benefit document and in coordination with the member’s physician(s). The plan makes coverage decisions on a case-by-case basis considering the individual member’s health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

This Pharmacy Medical Necessity Guideline does not apply to Uniformed Services Family Health Plan members or to certain delegated service arrangements. Unless otherwise noted in the member’s benefit document or applicable Pharmacy Medical Necessity Guideline, Pharmacy Medical Necessity Guidelines do not apply to CareLinkSM members. For self-insured plans, drug coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a coverage guideline and a self-insured member’s benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence.

For Tufts Health Plan Medicare Preferred, please refer to Tufts Health Plan Medicare Preferred Prior Authorization Criteria.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.