Pharmacy Management Drug Policy

SUBJECT: Chronic Hepatitis C (Pegasys, Peg-Intron, ribavirin, Sovaldi, Harvoni, ledipasvir/sofosbuvir, Viekira, Daklinza, Zepatier, Epclusa, sofosbuvir/velpatasvir, Vosevi, Mavyret) – For Managed Medicaid products
POLICY NUMBER: Pharmacy-21
EFFECTIVE DATE: 6/03
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If the member's subscriber contract excludes coverage for a specific service or prescription drug, it is not covered under that contract. In such cases, medical or drug policy criteria are not applied. Medical or drug policies apply to commercial and Health Care Reform products only when a contract benefit for the specific service exist.

DESCRIPTION:

Chronic infection with hepatitis C virus (HCV) is the most common cause of cirrhosis and hepatocellular carcinoma and the most frequent indication for liver transplant in the United States.

Certain terms have been defined in multiple ways in different studies and treatment guidelines. Below is a list of terms and their meanings for the purposes of this policy:

Rapid virologic response (RVR) - undetectable HCV at week 4

Sustained virologic response (SVR) - undetectable HCV at time of test (12, 24, 48 weeks)

Relapser- a person who has achieved an undetectable level of virus during a prior treatment course of PEG/RBV and relapsed after treatment was stopped

Non-responder- patient who fails to achieve undetectable HCV levels at any point during therapy. Non-responders include both **null-responders** and **partial responders**.

- **Null-responders** describe patients who experience a minimal viral suppression (serum HCV RNA levels declined less than 2 log10 IU/mL by week 12 during a prior treatment course)
- **Partial responders** are patients with a ≥ 2 log10 IU/mL response whose virus remained detectable up to 24 weeks or the end of treatment

Slow-responder- patient who has detectible HCV at weeks 4 and 12, but has undetectable HCV by week 24.

Undetectable (or negative) viral load – viral load is below the limit of detection for the specific test. e.g., a Branched-chain DNA (bDNA) test can only detect viral loads greater than 615 IU/mL.

Detectable (or positive) viral load - the presence of virus is above the limit of detection. This can be expressed as IU/mL, virus/mL, and in logarithmic format.

Aviremic- undetectable HCV RNA on quantitative test (less than 10 IU/mL on Taqman/TMA testing)

Initial Review Criteria – For All Treatment Regimens

Based upon our criteria and assessment of the peer-reviewed literature, **ribavirin, Peg-Intron, Pegasys Viekira, Sovaldi, Harvoni, ledipasvir/sofosbuvir, Daklinza, Zepatier, Epclusa, sofosbuvir/velpatasvir, Vosevi, and Mavyret** have been medically proven to be effective and therefore **medically necessary** in the treatment of Chronic Hepatitis C if the request meets **ALL** of the following criteria:

1. HCV genotype and quantitative baseline viral load must be provided with a collection date within twelve months before the start of therapy.
    A. If a patient has received hepatitis c treatment within the past 12 months, recent genotype test results taken after the completion of the previous treatment regimen, will be required to rule out re-infection.
2. The provider must assert to the patient's treatment readiness and ability to adhere to prescribed treatment regimen.

    A. At least one scale/assessment tool must have been utilized to evaluate readiness, such as the SAMHSA HRSA Center For Integrated Health Solutions- Drug & Alcohol screen tools (available at http://www.integration.samhsa.gov/clinical-practice/screening-tools#drugs) OR the Pyschosocial Readiness Evaluation and Preparation for hepatitis C treatment (PREP-C), available at http://prepc.org/

3. For Ribavirin-containing regimens, female patients of child bearing potential must have a negative pregnancy test collected within 30 days prior to the initiation of therapy OR Medical records must be submitted documenting pregnancy status.

4. Patients with limited life expectancy (<12 months due to **non-liver related comorbidities**) are not covered.

5. Progress notes are required on all new starts and recertifications.

6. Per IDSA/AASLD guidelines, Victrelis regimens are not recommended for any indication and therefore will only be authorized if there is documentation of a serious adverse reaction or contraindication to the other medications listed in this policy.

7. Patients who are previously cured will not be covered for any treatment upon reinfection unless the provider attests that risk factors for re-infection have been identified and addressed.

Drug Specific Criteria

Sofosbuvir/Velpatasvir (Authorized generic for Epclusa)

- Patient must be 18 years or older
- Coadministration of amiodarone with sofosbuvir/velpatasvir is not recommended due to risk of serious symptomatic bradycardia.
- Drugs that increase the gastric PH are expected to decrease concentrations of sofosbovir/velpatasvir. Coadministration of omeprazole or other proton-pump inhibitors is not recommended. If H2 receptor antagonists are taken, they should be administered simultaneously with or 12 hours apart from epclusa at a dose that does not exceed doses comparable to famotidine 40mg twice daily. It is recommended to separate antacid and sofosbuvir/velpatasvir administration by 4 hours.
- The safety and efficacy of sofosbuvir/velpatasvir is not recommended in patients with severe renal impairment/ESRD (CrCl <30 mL/min) or hemodialysis-patients in treatment guidelines and therefore is not covered.
- Coverage of sofosbuvir/velpatasvir is excluded in patients who have previously received treatment with a NS5A inhibitor.

1. For **genotype 1, 2, 4, 5, or 6** patients **without cirrhosis**, or with **compensated cirrhosis** (Child-Pugh A), sofosbuvir/velpatasvir will be **covered for 6 months to allow a total of 12 weeks of medication**, in patients who are treatment naïve or treatment experienced (defined as patients who have received treatment with peg interferon alfa/ribavirin with or without an HCV protease inhibitor).

2. For **genotype 3 treatment naïve** patients, with or without compensated cirrhosis and for genotype 3 **treatment experienced** (defined as patients who have received treatment with peg interferon alfa/ribavirin with or without an HCV protease inhibitor) patients **without cirrhosis**, sofosbuvir/velpatasvir will be covered for 6 months to allow a total of 12 weeks of medication.

3. For **genotype 3 treatment experienced** (defined as patients who have received treatment with peg interferon alfa/ribavirin with or without an HCV protease inhibitor) patients with **compensated cirrhosis**, sofosbuvir/velpatasvir will be **covered for 6 months to allow a total of 12 weeks of medication in combination with ribavirin**. AASLD guidelines recommend the addition of ribavirin to increase SVR12 rates, unless contraindicated. If a patient is ineligible to receive ribavirin, sofosbuvir/velpatasvir will be covered alone for 12 weeks of medication (approval period will be 6 months).

4. For **genotype 1, 2, 3, 4, 5, or 6** patients with **decompensated** cirrhosis (Child-Pugh B or C), sofosbuvir/velpatasvir will be covered for 6 months to allow a total of 12 weeks of medication **in combination with ribavirin**.

- If patient is ribavirin ineligible, approval will be for 24 weeks as monotherapy. Please see policy guidelines for definition of those who are considered ribavirin ineligible.

5. For **genotype 2** patients who are **sofosbuvir and ribavirin experienced**, sofosbuvir/velpatasvir will be covered **in combination with ribavirin** for 6 months to allow a total of 12 weeks of medication.

Ledipasvir/Sofosbuvir (authorized generic for Harvoni)

- Patient **must have genotype 1, 4, 5 or 6** and be 3 years or older.
- Ledipasvir/sofosbuvir is not covered in patients with severe renal impairment/ESRD (CrCl <30 mL/min) or hemodialysis-patients.
- Ledipasvir/sofosbuvir is covered as monotherapy or in combination with ribavirin only.
- Please see policy guidelines for definition of cirrhosis.
- Drugs that decrease the gastric PH are expected to decrease concentration of Ledipasvir. Proton-pump inhibitor doses comparable to omeprazole 20mg or lower can be administered simultaneously with ledipasvir/sofosbuvir under fasted conditions. If H2 receptor antagonists are taken, they should be administered simultaneously with or 12 hours apart from ledipasvir/sofosbuvir at a dose that does not exceed doses comparable to famotidine 40mg twice daily. It is recommended to separate antacid and ledipasvir/sofosbuvir administration by 4 hours.
- Coadministration of amiodarone with ledipasvir/sofosbuvir is not recommended due to risk of serious symptomatic bradycardia

1. For **genotype 1 treatment-naïve patients without cirrhosis** who have **pre-treatment HCV RNA less than 6 million IU/mL,** approval will be for **6 months to allow a total of 8 weeks of medication for completion of therapy.**

   a. For treatment-naive patients who are **HIV-HCV co-infected**, **African American**, or who have documentation of a **CT or TT type IL28B polymorphism**, approval will be for 6 months to allow 12 weeks for completion of therapy, in patients that have documentation of severe intolerance (that prevents completion of therapy) or contraindication to sofosbuvir-velpatasvir.

2. For **genotype 1 treatment-naïve patients without cirrhosis** who have **pre-treatment HCV RNA more than 6 million IU/mL,** approval will be for 6 months to allow a total of **12 weeks of medication for completion of therapy,** in patients that have documentation of severe intolerance (that prevents completion of therapy) or contraindication to sofosbuvir-velpatasvir.

3. For **genotype 1 treatment-naïve patients with compensated cirrhosis,** approval will be for 6 months to allow a total of **12 weeks of medication for completion of therapy**, in

patients that have documentation of severe intolerance (that prevents completion of therapy) or contraindication to sofosbuvir-velpatasvir.

4. For **genotype 1 treatment-experienced** (defined as patients who have failed an interferon based regimen with or without ribavirin) **without cirrhosis**, approval will be for 6 months to allow a total of **12 weeks of medication for completion of therapy,** in patients that have documentation of severe intolerance (that prevents completion of therapy) or contraindication to sofosbuvir-velpatasvir.

5. For **genotype 1 treatment-experienced** (defined as patients who have failed an interferon based regimen with or without ribavirin) **with compensated cirrhosis, initial approval will be for 6 months to allow a total of 12 weeks of Harvoni with ribavirin,** in patients that have documentation of severe intolerance (that prevents completion of therapy) or contraindication to sofosbuvir-velpatasvir**.**

   a. Requests for 24 week monotherapy with ledipasvir/sofosbuvir require documentation of severe intolerance (that prevents completion of therapy) or contraindication to sofosbuvir/velpatasvir. In addition, documentation of severe intolerance or contraindication to ribavirin is required. Please see policy guidelines for definition of those who are considered ribavirin ineligible. Approval period will be for 6 months to allow a total of 24 weeks of medication for completion of therapy.

6. For retreatment of **genotype 1** patients who previously **failed Sovaldi**, the patient must have the same genotype infection on relapse to rule out reinfection**. Approval will be for 6 months to allow a total of 12 weeks of ledipasvir/sofosbuvir with Ribavirin** in patients **without cirrhosis** that have documentation of severe intolerance (that prevents completion of therapy) or contraindication to sofosbuvir-velpatasvir.

7. For **genotype 4**, ledipasvir/sofosbuvir is approved for 6 months to allow a total of 12 weeks of medication in treatment naïve or treatment experienced patients (defined as patients who have failed an interferon based regimen with or without ribavirin), with or without cirrhosis, that have documentation of severe intolerance (that prevents completion of therapy) or contraindication to sofosbuvir-velpatasvir.

8. For **genotype 5 or 6**, ledipasvir/sofosbuvir approval will be for 6 months to allow a total of 12 weeks of medication in treatment naïve or treatment experienced (defined as patients who have failed an interferon based regimen with or without ribavirin) patients, with or without compensated cirrhosis, that have documentation of severe intolerance (that prevents completion of therapy) or contraindication to sofosbuvir-velpatasvir.

9. For **post-liver transplant** patients, approval will be for 6 months to allow a total of 12 weeks of ledipasvir/sofosbuvir **in combination with ribavirin.** For treatment naïve patients who are ribavirin ineligible, approval will be for 24 weeks as monotherapy. Please see policy guidelines for definition of those who are considered ribavirin ineligible.

10. For **genotype 1 or 4, 5 or 6** patients who have **decompensated cirrhosis (Class B or C)**,

who may or may not be candidates for liver transplantation, including those with Hepatocellular carcinoma**, approval will be for 6 months to allow a total of 12 weeks of medication for completion of therapy** in combination with ribavirin when there is documentation of severe intolerance (that prevents completion of therapy) or contraindication to sofosbuvir-velpatasvir**.** If patient is ribavirin ineligible, approval will be for 24 weeks as monotherapy when there is documentation of severe intolerance (that prevents completion of therapy) or contraindication to sofosbuvir-velpatasvir. Please see policy guidelines for definition of those who are considered ribavirin ineligible.

Mavyret (glecaprevir and pibrentasvir)

- Patient must be 12 years or older or weigh at least 45 kg
- Mavyret will not be covered in patients with moderate or severe hepatic impairment (Child-Pugh B or C).
- Mayvret is contraindicated with atazanavir or rifampin and therefore will not be covered in patient's taking atazanavir or rifampin.

1. For **genotype 1,2,3,4,5 or 6** patients, who are **treatment naïve**, **without cirrhosis**, approval will be **for 6 months to allow a total of 8 weeks of medication** for completion of therapy.

2. For **genotype 1,2,3,4,5 or 6** patients, who **are treatment naïve**, **with compensated cirrhosis** (Child Pugh A), approval will be for 6 months to allow a total of **8 weeks** of medication for completion of therapy.

3. For **genotype 1,2,4,5, or 6** patients **without cirrhosis** who are **treatment experienced with regimens containing interferon, pegylated interferon, ribavirin, and/or sofosbuvir**, but have no prior treatment experienced with an HCV NS3/4A Protease inhibitor or NS5A inhibitor, approval will be for 6 months to allow a total of **8 weeks** of medication for completion of therapy.

4. For **genotype 1,2,4,5, or 6** patients, **with compensated cirrhosis** (Child Pugh A), who are **treatment experienced with regimens containing interferon, pegylated interferon, ribavirin, and/or sofosbuvir**, but have no prior treatment experienced with an HCV NS3/4A Protease inhibitor or NS5A inhibitor, approval will be for 6 months to allow a total of **12 weeks** of medication for completion of therapy.

5. For **genotype 3** patients, **without cirrhosis or with compensated cirrhosis** (Child Pugh A), who are **treatment experienced with regimens containing interferon, pegylated interferon, ribavirin, and/or sofosbuvir**, but have no prior treatment experienced with an HCV NS3/4A Protease inhibitor or NS5A inhibitor, approval will be for 6 months to allow a total of **16 weeks** of medication for completion of therapy.

6. For **genotype 1 patients without cirrhosis or with compensated cirrhosis (Child Pugh A),** who have previously failed treatment with a prior regimen containing Harvoni (ledipasvir) or Daklinza (daclatasvir), but have no prior treatment with an

HCV NS3/4A Protease inhibitor, the patient must have the same genotype infection on relapse to rule out re-infection**.** Approval will be for 6 months to allow a total of **16 weeks of medication** for completion of therapy.

- The following medications are considered NS3/4A protease inhibitor or NS3/4A inhibitor- containing products: Olysio (simeprevir capsules), Victrelis (boceprevir capsules), Incivek (telaprevir tablets), Technivie (ombitasvir/paritaprevir/ritonavir tablets), Viekira Pak (ombitasvir/paritaprevir/ritonavir tablets; dasabuvir tablets, co-packaged), Viekira XR (dasabuvir/ombitasvir/paritaprevir/ritonavir extended-release tablets), Vosevi (sofosbuvir/velpatasvir/voxilaprevir), or Zepatier (elbasvir/grazoprevir tablets).

7. For **genotype 1** patients **without cirrhosis or with compensated cirrhosis (Child Pugh A),** who have previously failed treatment with an HCV NS3/4A Protease inhibitor, but have no prior treatment with an HCV NS5A inhibitor, the patient must have the same genotype infection on relapse to rule out re-infection**.** Approval will be for 6 months to allow a total of **12 weeks of medication** for completion of therapy.

    - The following medications are considered NS5A inhibitor or NS5A inhibitor- containing products: Harvoni (ledipasvir/sofosbuvir tablets), Epclusa (sofosbuvir/velpatasvir), Zepatier (elbasvir/grazoprevir tablets), Daklinza (daclatasvir tablets), Technivie (ombitasvir/paritaprevir/ritonavir tablets), Viekira Pak (ombitasvir/paritaprevir/ritonavir tablets; dasabuvir tablets, co-packaged), Viekira XR (dasabuvir/ombitasvir/paritaprevir/ritonavir extended-release tablets), or Vosevi (sofosbuvir/velpatasvir/voxilaprevir).

8. For patients who have not failed treatment with an HCV NS5A inhibitor, Mavyret will not be authorized for new starts unless there is documentation of severe intolerance (that prevents completion of therapy) or contraindication with sofosbuvir-velpatasvir and ledipasvir-sofosbuvir

9. For genotype 1 and 4 patients who have chronic kidney disease (CKD) stage 4 or 5 (eGFR <30ml/min or End-stage Renal disease), Mavyret will not be authorized for new starts unless there is documentation of severe intolerance (that prevents completion of therapy) or contraindication with Zepatier

10. For **genotype 1-6 patients** who have had **treatment failure with Mavyret**, Mavyret will not be authorized unless there is documentation of severe intolerance (that prevents completion of therapy) or contraindication with Vosevi (sofosbuvir/velpatasvir/voxilaprevir)

Zepatier (elbasvir and grazoprevir)

- Patient must have genotype 1 or 4 and must be 18 years or older
    - For genotype 1 patients, the specific subtype (genotype 1a or 1b) must be provided.

- Zepatier will not be covered for patient with moderate or severe hepatic impairment (Child-Pugh B or C).
- Zepatier will not be covered when being prescribed in patients who are on OATP1B1/3 inhibitors, strong CYP3A inducers, or efavirenz.
- The safety and efficacy of Zepatier have not been established in patients awaiting liver transplant or in liver transplant recipients.

1. For **genotype 1a patients**:
    a. For **treatment naïve** or **peg-interferon/ribavirin experienced** patients **without** baseline NS5A polymorphisms at amino acid positions 28,30, 31, or 93, approval will be for 6 months to allow a total of 12 weeks of Zepatier monotherapy.
    b. For **treatment naïve** or **peg-interferon/ribavirin experienced** patients **WITH** baseline NS5A polymorphisms at amino acid positions 28, 30, 31, or 93, approval will be for 6 months to allow a total of 16 weeks of Zepatier **in combination with ribavirin.**
    c. For genotype 1a patients who are **Peg-interferon/ribavirin/protease inhibitor experienced,** approval will be for 6 months to allow a total of 12 weeks of Zepatier in **combination with Ribavirin.**

2. For **genotype 1b patients** who are **treatment naïve** or **peg-interferon/ribavirin experienced**, approval will be for 6 months to allow a total of 12 weeks of Zepatier monotherapy.

3. For **genotype 1b** patients who are **peg-interferon/ribavirin/protease inhibitor** experienced, approval will be for 6 months to allow a total of 12 weeks of Zepatier in **combination with ribavirin.**

4. For **genotype 3, peg interferon/ribavirin treatment experienced** patients, with **compensated cirrhosis**, Zepatier will not be authorized for new starts unless there is documentation of severe intolerance (that prevents completion of therapy) with Epclusa or contraindication to Epclusa. For these patients, approval will be for 6 months to allow a total of 12 weeks of Zepatier in combination with Sovaldi.

5. For **genotype 4** patients who are treatment naïve, approval will be for 6 months to allow a total of **12 weeks** of Zepatier monotherapy.

6. For **genotype 4** patients who experienced virologic relapse after prior Peg-interferon/ribavirin therapy, approval will be for 6 months to allow a total of **12 weeks of Zepatier in combination with Ribavirin**. For geonotype 4 patients who experienced prior on-treatment virologic failure (failure to suppress or breakthrough) while on peg-interferon/ribavirin, approval will be for 6 months to allow a total of **16 weeks of Zepatier in combination with ribavirin.**

7. Zepatier will not be authorized for new starts unless there is documentation of severe intolerance (that prevents completion of therapy) or contraindication with sofosbuvir-

velpatasvir and ledipasvir-velpatasvir.

Harvoni (ledipasvir/sofosbuvir)

- Patient **must have genotype 1, 4, 5 or 6** and be 3 years or older
- Harvoni is not covered in patients with severe renal impairment/ESRD (CrCl <30 mL/min) or hemodialysis-patients.
- Harvoni is covered as monotherapy or in combination with ribavirin only.
- Harvoni 45/200mg tablets will not be covered in patients that weigh 35 kg or more, due to the availability of 90/400mg tablets which can be used in these patients.
- Please see policy guidelines for definition of cirrhosis.
- Drugs that decrease the gastric PH are expected to decrease concentration of Ledipasvir. Proton-pump inhibitor doses comparable to omeprazole 20mg or lower can be administered simultaneously with Harvoni under fasted conditions. If H2 receptor antagonists are taken, they should be administered simultaneously with or 12 hours apart from Harvoni at a dose that does not exceed doses comparable to famotidine 40mg twice daily. It is recommended to separate antacid and Harvoni administration by 4 hours.
- Coadministration of amiodarone with Harvoni is not recommended due to risk of serious symptomatic bradycardia

1. For **genotype 1 treatment-naïve patients without cirrhosis** who have **pre-treatment HCV RNA less than 6 million IU/mL,** approval will be for **6 months to allow a total of 8 weeks of medication for completion of therapy.**

   a. For treatment-naive patients who are **HIV-HCV co-infected**, **African American**, or who have documentation of a **CT or TT type IL28B polymorphism**, approval will be for 6 months to allow 12 weeks for completion of therapy, in patients that have documentation of severe intolerance (that prevents completion of therapy) or contraindication to sofosbuvir-velpatasvir.

2. For **genotype 1 treatment-naïve patients without cirrhosis** who have **pre-treatment HCV RNA more than 6 million IU/mL,** approval will be for 6 months to allow a total of **12 weeks of medication for completion of therapy,** in patients that have documentation of severe intolerance (that prevents completion of therapy) or contraindication to sofosbuvir-velpatasvir.

3. For **genotype 1 treatment-naïve patients with compensated cirrhosis,** approval will be for 6 months to allow a total of **12 weeks of medication for completion of therapy**, in patients that have documentation of severe intolerance (that prevents completion of therapy) or contraindication to sofosbuvir-velpatasvir.

4. For **genotype 1 treatment-experienced** (defined as patients who have failed an interferon

based regimen with or without ribavirin) **without cirrhosis**, approval will be for 6 months to allow a total of **12 weeks of medication for completion of therapy,** in patients that have documentation of severe intolerance (that prevents completion of therapy) or contraindication to sofosbuvir-velpatasvir.

5. For **genotype 1 treatment-experienced** (defined as patients who have failed an interferon based regimen with or without ribavirin) **with compensated cirrhosis, initial approval will be for 6 months to allow a total of 12 weeks of Harvoni with ribavirin,** in patients that have documentation of severe intolerance (that prevents completion of therapy) or contraindication to sofosbuvir-velpatasvir**.**

   a. Requests for 24 week monotherapy with Harvoni require documentation of severe intolerance (that prevents completion of therapy) or contraindication to sofosbuvir-velpatasvir. In addition, documentation of severe intolerance or contraindication to ribavirin is required. Please see policy guidelines for definition of those who are considered ribavirin ineligible. Approval period will be for 6 months to allow a total of 24 weeks of medication for completion of therapy.

6. For retreatment of **genotype 1** patients who previously **failed Sovaldi**, the patient must have the same genotype infection on relapse to rule out reinfection**. Approval will be for 6 months to allow a total of 12 weeks of Harvoni with Ribavirin** in patients **without cirrhosis** that have documentation of severe intolerance (that prevents completion of therapy) or contraindication to sofosbuvir-velpatasvir.

7. For **genotype 4**, Harvoni is approved for 6 months to allow a total of 12 weeks of medication in treatment naïve or treatment experienced (defined as patients who have failed an interferon based regimen with or without ribavirin) patients, with or without cirrhosis, that have documentation of severe intolerance (that prevents completion of therapy) or contraindication to sofosbuvir-velpatasvir.

8. For **genotype 5 or 6**, Harvoni approval will be for 6 months to allow a total of 12 weeks of medication in treatment naïve or treatment experienced (defined as patients who have failed an interferon based regimen with or without ribavirin) patients, with or without compensated cirrhosis, that have documentation of severe intolerance (that prevents completion of therapy) or contraindication to sofosbuvir-velpatasvir.

9. For **post-liver transplant** patients, approval will be for 6 months to allow a total of 12 weeks of Harvoni **in combination with ribavirin.** For treatment naïve patients who are ribavirin ineligible, approval will be for 24 weeks as monotherapy. Please see policy guidelines for definition of those who are considered ribavirin ineligible.

10. For **genotype 1 or 4, 5 or 6** patients who have **decompensated cirrhosis (Class B or C)**, who may or may not be candidates for liver transplantation, including those with Hepatocellular carcinoma, treatment is **covered in combination with ribavirin for 12 weeks. Approval will be for 6 months to allow a total of 12 weeks of medication for completion of therapy.** If patient is ribavirin ineligible, approval will be for 24 weeks as

monotherapy. Please see policy guidelines for definition of those who are considered ribavirin ineligible.

11. For adult patients, Harvoni will not be authorized for new starts unless there is documentation of severe intolerance (that prevents completion of therapy) or contraindication with sofosbuvir-velpatasvir and ledipasvir-sofosbuvir. For pediatric patients younger than 18 years of age that weigh 35 kg or more, Harvoni will not be authorized for new starts unless there is documentation of severe intolerance (that prevents completion of therapy) or contraindication with ledipasvir-sofosbuvir. For pediatric patients that weigh less than 35 kg, the use of sofosbuvir-velpatasvir or ledipasvir-sofosbuvir will not be required prior to the use of Harvoni.

Epclusa (sofosbuvir/velpatasvir)

- Patient must be 18 years or older
- Coadministration of amiodarone with Epclusa is not recommended due to risk of serious symptomatic bradycardia.
- Drugs that increase the gastric PH are expected to decrease concentrations of Velpatasvir. Coadministration of omeprazole or other proton-pump inhibitors is not recommended. If H2 receptor antagonists are taken, they should be administered simultaneously with or 12 hours apart from epclusa at a dose that does not exceed doses comparable to famotidine 40mg twice daily. It is recommended to separate antacid and Epclusa administration by 4 hours.
- The safety and efficacy of Epclusa is not recommended in patients with severe renal impairment/ESRD (CrCl <30 mL/min) or hemodialysis-patients in treatment guidelines and therefore is not covered.
- Coverage of Epclusa is excluded in patients who have previously received treatment with a NS5A inhibitor.

1. For **genotype 1, 2, 4, 5, or 6** patients **without cirrhosis**, or with **compensated cirrhosis** (Child-Pugh A), Epclusa will be **covered for 6 months to allow a total of 12 weeks of medication**, in patients who are treatment naïve or treatment experienced (defined as patients who have received treatment with peg interferon alfa/ribavirin with or without an HCV protease inhibitor).

2. For **genotype 3 treatment naïve** patients, with or without compensated cirrhosis and for genotype 3 **treatment experienced** (defined as patients who have received treatment with peg interferon alfa/ribavirin with or without an HCV protease inhibitor) patients **without cirrhosis**, Epclusa will be covered for 6 months to allow a total of 12 weeks of medication.

3. For **genotype 3 treatment experienced** (defined as patients who have received treatment with peg interferon alfa/ribavirin with or without an HCV protease inhibitor) patients with **compensated cirrhosis**, Epclusa will be **covered for 6 months to allow**

a total of 12 weeks of medication in combination with ribavirin. AASLD guidelines recommend the addition of ribavirin to increase SVR12 rates, unless contraindicated. If a patient is ineligible to receive ribavirin, Epclusa will be covered alone for 12 weeks of medication (approval period will be 6 months).

4. For **genotype 1, 2, 3, 4, 5, or 6** patients with **decompensated** cirrhosis (Child-Pugh B or C), Epclusa will be covered for 6 months to allow a total of 12 weeks of medication **in combination with ribavirin**.

5. For **genotype 2** patients who are **sofosbuvir and ribavirin experienced**, Epclusa will be covered **in combination with ribavirin** for 6 months to allow a total of 12 weeks of medication.

6. Epclusa will not be authorized for new starts unless there is documentation of severe intolerance (that prevents completion of therapy) with sofosbuvir/velpatasvir and ledipasvir/sofosbuvir or contraindication to sofosbuvir/velpatasvir and ledipasvir/sofosbuvir.

Sovaldi-Based Regimens

- Patient must be 3 years or older.
- Sovaldi will not be authorized as monotherapy.
- The safety and efficacy of Sovaldi is not recommended in patients with severe renal impairment/ESRD (CrCl <30 mL/min) or hemodialysis-patients in treatment guidelines and therefore is not covered.
- Sovaldi 200mg tablets will not be covered in patients weighing 35 kg or more due to the availability of 400mg tablets, which can be used in these patients.

1. Due to the availability of other equally effective, but more cost-effective FDA approved treatment regimens, Sovaldi will **NOT** be covered for **genotype 1** patients.

2. For **genotypes 2 or 3**, Sovaldi will not be covered unless there is documentation of a severe intolerance (that prevents completion of therapy) or contraindication to sofosbuvir/velpatasvir. For pediatric patients that are less than 18 years of age with genotypes 2 or 3, the use of sofosbuvir/velpatasvir will not be required prior to Sovaldi.

   For patients who have documentation of severe intolerance (that prevents completion of therapy) or contraindication to sofosbuvir/velpatasvir, coverage will be provided as follows:

   a. For **genotype 2 and 3** patients who are treatment naïve or Peg-interferon/ribavirin experienced **without cirrhosis**, Sovaldi will be covered in combination with

daclatasvir (Daklinza) for 12 weeks of medication (approval period will be 6 months).

b. **For genotype 2 patients** who are treatment naïve or peginterferon/ribavirin experienced with **compensated cirrhosis**, Sovaldi will be approved in combination with daclatasvir (Daklinza) for 16 or 24 weeks[1] of medication (approval period will be 6 months).

c. For **genotype 3 patients** who are treatment naïve with compensated cirrhosis, Sovaldi will be covered in combination with daclatasvir (Daklinza)**,** with or without ribavirin for 24 weeks[1] of medication (approval period will be 6 months).

d. For **genotype 3 patients** who are Peg interferon and ribavirin experienced with compensated cirrhosis, Sovaldi will be covered in combination with daclatasvir (Daklinza) and Ribavirin for 24 weeks[1] of medication (approval period will be 6 months).

e. For **genotype 2** patients who are **Sofosbuvir (Sovaldi) plus ribavirin treatment experienced**, Sovaldi will be approved in combination with daclatasvir (Daklinza) with or without weight based ribavirin for 24 weeks of medication (approval period will be 6 months).

3. For patients with **decompensated cirrhosis**, Sovaldi will not be covered unless there is documentation of a severe intolerance (that prevents completion of therapy) or contraindication to sofosbuvir/velpatasvir.

4. For Pediatric patients 12- 18 years of age or who weigh at least 35 kg, Sovaldi (in combination with ribavirin) will not be covered unless there is documentation of severe intolerance (that prevents completion of therapy) or contraindication to Mavyret.

5. For **Genotype 1-6 patients** who have **had treatment failure with Mavyret** (glecaprevir/pibrentasvir), Sovaldi will not be covered unless there is documentation of severe intolerance (that prevents completion of therapy) or contraindication to Vosevi (sofosbuvir/velpatasvir/voxilaprevir).

Daklinza (daclatasvir)/Sovaldi (sofosbuvir) combination

- Must be 18 years of age or older
- Daklinza will not be authorized as monotherapy
- Daklinza is contraindicated in combination with drugs that strongly induce CYP3A and may lead to lower exposure and loss of efficacy. These medications include phenytoin, carbamazepine, rifampin, and St. John's wort.

1. Due to the availability of other equally effective, but more cost-effective FDA approved treatment regimens, Daklinza will **NOT** be covered for **genotype 1** patients.

2. For **genotypes 2 or 3**, Daklinza will not be covered unless there is documentation of a severe intolerance (that prevents completion of therapy) or contraindication to sofosbuvir/velpatasvir. For patient patients who have documentation of severe intolerance (that prevents completion of therapy) or contraindication to sofosbuvir/velpatasvir, coverage will be provided as follows:

    a. For **genotype 2 and 3** patients who are treatment naïve or Peg-interferon/ribavirin experienced **without cirrhosis**, Daklinza will be covered in combination with Sobosbuvir (Sovaldi) for 12 weeks of medication (approval period will be 6 months).

    b. **For genotype 2 patients** who are treatment naïve or peginterferon/ribavirin experienced with **compensated cirrhosis**, Daklinza will be approved in combination with Sofosbuvir (Sovaldi) for 16 or 24 weeks[1] of medication (approval period will be 6 months).

    c. For **genotype 3 patients** who are treatment naïve with compensated cirrhosis, Daklinza will be covered in combination with Sofosbuvir (Sovaldi), with or without ribavirin for 24 weeks[1] of medication (approval period will be 6 months).

    d. For **genotype 3 patients** who are Peg interferon and ribavirin experienced with compensated cirrhosis, Daklinza will be covered in combination with Sofosbuvir (Sovaldi) and Ribavirin for 24 weeks[1] of medication (approval period will be 6 months).

    e. For **genotype 2** patients who are **Sofosbuvir (Sovaldi) plus ribavirin treatment experienced**, Daklinza will be approved in combination with sofosbuvir (Sovaldi) with or without weight based ribavirin for 24 weeks of medication (approval period will be 6 months).

3. For patients with decompensated cirrhosis, Daklinza will not be covered unless there is documentation of a severe intolerance (that prevents completion of therapy) or contraindication to sofosbuvir/velpatasvir.

Vosevi (sofosbuvir/velpatasvir/voxilaprevir)

- Patient must be 18 years or older
- Coadministration of amiodarone with Vosevi is not recommended due to risk of serious symptomatic bradycardia.
- Coadministration of Vosevi with HIV regimens containing atazanavir, lopinavir, tipranavir/ritonavir, and efavirenz is not recommended.
- Drugs that increase the gastric PH are expected to decrease concentrations of Velpatasvir. Antacids should be separated from Vosevi administration by 4 hours. H2 receptor Antagonists may be administered simultaneously with or staggered from Vosevi at a dose that does not exceed doses comparable with famotidine 40mg twice daily. Omeprazole 20mg can be administered with Vosevi. Use with other proton Pump-inhibitors has not been studied.
- The safety and efficacy of Vosevi is not recommended in patients with severe renal impairment/ESRD (CrCl <30 mL/min) or hemodialysis-patients in FDA labeling, and therefore, is not covered.
- Vosevi will not be covered in patients with moderate or severe hepatic impairment (Child-Pugh B or C).

1. For **genotypes 1,2,3,4,5 or 6** patients **without cirrhosis** or with **compensated cirrhosis**, who have previously failed treatment with an NS5A inhibitor, (daclatasvir, elbasavir, ledipasvir, ombitasvir, or velpatasvir), the patient must have the same genotype infection on relapse to rule out re-infection. Approval will be for 6months to allow a total of **12 weeks** of medication for completion of therapy.

2. For **genotypes 1a or 3** patients **without cirrhosis** or **with compensated cirrhosis**, who have previously failed treatment with a Sovaldi (Sofosbuvir) containing regimen without an NS5A inhibitor, the patient must have the same genotype on relapse to rule out re-infection. Approval will be for 6 months to allow a total of **12 weeks of medication** for completion of therapy.

3. For **genotype 1-6 patients without compensated cirrhosis**, who have had **previous treatment failure with Mavyret,** the patient must have the same genotype on relapse to rule out re-infection, Approval of Vosevi will be for 6 months to allow a total of 12 weeks of medication. For **genotype 1-6 patients with compensated cirrhosis**, who have had **previous treatment failure with Mavyret**, the patient must have the same genotype on relapse to rule out re-infection. Approval will be for 6 months to allow a total of 12 weeks of Vosevi **in combination with ribavirin.**

POLICY GUIDELINES:

1. Prior-authorization is contract dependent.

2. For contracts where Insurance Law § 4903(c-1), and Public Health Law § 4903(3-a) are applicable, if trial of preferred drugs(s) is the only criterion that is not met for a given condition and one of the following circumstances can be substantiated by the requesting provider, then trial of the preferred drug(s) will not be required.

- The required prescription drug(s) is (are) contraindicated or will likely cause an adverse reaction or physical or mental harm to the member;
- The required prescription drug is expected to be ineffective based on the known clinical history and conditions and concurrent drug regimen;
- The required prescription drug(s) was (were) previously tried while under the current or a previous health plan, or another prescription drug or drugs in the same pharmacologic class or with the same mechanism of action was (were) previously tried and such prescription drug(s) was (were) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
- The required prescription drug(s) is (are) not in the patient's best interest because it will likely cause a significant barrier to adherence to or compliance with the plan of care, will likely worsen a comorbid condition, or will likely decrease the ability to achieve or maintain reasonable functional ability in performing daily activities;
- The individual is stable on the requested prescription drug. The medical profile of the individual (age, disease state, comorbidities), along with the rational for deeming stability as it relates to standard medical practice and evidence-based practice protocols for the disease state will be taken into consideration.
- The above criteria are not applicable to requests for brand name medications that have an AB rated generic. We can require a trial of an AB-rated generic equivalent prior to providing coverage for the equivalent brand name prescription drug.

3. Cirrhosis as defined as any one of the following:
    a. Liver biopsy showing cirrhosis (e.g., Metavir score = 4 or Ishak score ≥ 5) OR
    b. FibroTest® score of > 0.75 AND an APRI > 2 OR
    c. Nodular liver morphology on abdominal ultrasound or CT scan.

4. In the absence of a definitive diagnosis of presence or absence of cirrhosis by the above criteria, a liver biopsy is required; liver biopsy results will supersede blood test results and be considered definitive.

5. Ineligibility to ribavirin is defined as:
    a. Neutrophils <750 cells/mm3,results within the past month or
    b. Hemoglobin < 10g/dL, results within the past month or
    c. Platelets <50 000 cells/ mm3, results within the past month or
    d. Autoimmune hepatitis or other autoimmune condition known to be exacerbated by Ribavirin
    e. Severe intolerance to past ribavirin therapy

6. Ineligibility to interferon therapy are defined as:

    a. Comorbid autoimmune hepatitis or other autoimmune disorders or
    b. Decompensated hepatic disease or history of preexisting cardiac disease or
    c. A baseline neutrophil count below 1500/µL or
    d. A baseline platelet count below 90,000/µL or
    e. Baseline hemoglobin below 10 g/dL or
    f. Major uncontrolled depressive illness **despite pharmacologic treatment**, or

g. **Severe intolerance to past IFN therapy** (such as urticaria, angioedema, broncho constriction, anaphylaxis, Stevens-Johnson syndrome, ophthalmologic disorder, thyroid disorder or refractory diabetes mellitus).

7. No early refills will be allowed without a prior authorization to document necessity.

8. Treatment regimens that are not listed within the policy will be evaluated based on current treatment guidelines for safety and efficacy.
    a. Treatment regimens must be listed as a class IIa or higher recommendation in the AASLD HCV guidance or DrugDex to be considered for coverage. Approval period for these regimens will be 6 months, but the treatment amount will be limited to the specific treatment regimen (number of weeks) that is consistent with AASLD HCV guidance or DrugDex.

9. Triple therapy with Olysio is not recommended for any genotype and therefore is not included in the policy.

UPDATES:

Date:	Revision:
1/20	Revision
11/19	Revision
10/19	Revision
6/19	Revision
2/19	Revision/P&T Approval
10/18	Revision
8/18	Revision
4/18	Revision
9/17	Revision/P&T Approval
8/17	Revision
7/17	Revision
3/17	Revision
8/16	Revision
6/16	Revision
4/16	Revision
3/16	Revision
2/16	Revision
11/15	Revision
8/15	Revision
7/15	Revision
5/15	Revision
2/15	Revision
1/15	Revision
11/14	Revision

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