Clinical Policy: Infectious Disease Agents: Antivirals – Hepatitis C Agents

Reference Number: OH.PHAR.PPA.71
Effective Date: 01.20
Last Review Date: 10.20
Line of Business: Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description:

INFECTIOUS DISEASE AGENTS: HEPATITIS C – DIRECT-ACTING ANTIVIRAL

CLINICAL PA REQUIRED "PREFERRED"†	PA REQUIRED "NON-PREFERRED"
SOFOSBUVIR/VELPATASVIR (generic of EPCLUSA®) [Labeler 72626] MAVYRET® (glecaprevir and pibrentasvir)	DAKLINZA™ (daclatasvir) LEDIPASVIR/SOFOSBUVIR (generic of HARVONI®) SOVALDI® (sofosbuvir) VOSEVI™ (sofosbuvir, velpatasvir, voxilaprevir) ZEPATIER™ (elbasvir and grazoprevir tablet)

†Selection of regimen will be based upon guidelines; refer to PA form for guidance.

INFECTIOUS DISEASE AGENTS: HEPATITIS C - PEGYLATED INTERFERONS

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
PEGASYS® (peginterferon alfa-2a) PEG-INTRON® (peginterferon alfa-2b)	

INFECTIOUS DISEASE AGENTS: HEPATITIS C - RIBAVIRINS

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
RIBAVIRIN (generic of Rebetol®)	COPEGUS® (ribavirin) MODERIBA PAK® (ribavirin) RIBAPAK® (ribavirin) RIBASPHERE® (ribavirin) 400mg, 600mg

FDA Approved Indication(s):
For the treatment of chronic Hepatitis C infections.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of Buckeye Health Plan, an affiliate with Centene Corporation®, that Epclusa, Mavyret, Daklinza, Harvoni, Sovaldi, Vosevi, Zepatier, Pegasys, PEG-Intron, Ribavirin,

Copegus, Moderiba Pak, Ribapak, and Ribasphere are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Chronic Hepatitis C Infection (must meet all)**:**

NOTE: All Hepatitis C Virus (HCV) DAAs require clinical prior authorization. Only regimens listed as recommended or alternative by the American Association for the Study of Liver Diseases (AASLD) will be approved with duration of approval based upon guidelines. Regimens listed as not recommended will not be approved. Members must meet ALL criteria below:

1. Confirmation of chronic Hepatitis C;
2. Must be prescribed by, or in consultation with, a hepatologist, gastroenterologist, or infectious disease specialist;
3. Reactive Hepatitis C Virus (HCV) antibody test;
4. HCV RNA load measured within 6 months prior to starting therapy;
5. Confirmed HCV genotype;
6. Member must meet labeled age requirements for the medication;
7. Member must meet kidney function as indicated in package labeling for product;
8. Member must not be concomitantly taking drugs that have significant clinical interaction as described in the prescribing information for each agent;
9. Member must agree to be adherent with office visits, lab testing, imaging, procedures and, if deemed a candidate, the HCV medication regimen. Prescriber must submit documentation demonstrating the member attests to meet these requirements (office notes documenting this are sufficient to meet this criteria);
10. Documentation of degree of liver fibrosis, documentation of the method used, and date fibrosis score was obtained. Acceptable tests include liver biopsy OR one radiological and one serological test;
11. Documentation of cirrhosis status of the member (no cirrhosis, compensated cirrhosis, or decompensated cirrhosis) AND documentation of Child-Turcotte-Pugh (CTP) score;

NOTE: Members with decompensated cirrhosis (CTP score 7 or higher) will be approved for therapy only after consultation with a physician in a liver transplant center.

12. Member does not have limited life expectancy (less than 12 months) due to non-liver-related comorbid conditions;
13. Documentation of any previously tried Hepatitis C treatments, dates treated, and response/outcome (member will not be approved if any other HCV treatments have been used in the last 180 days);
14. If prescribed regimen includes ribavirin, the following criteria must be met (must meet all):
    a. Member or member's partner(s) is NOT pregnant and is NOT planning to become pregnant;
    b. Agreement that member and their partner(s) will use two forms of effective contraception during treatment;
15. Documentation that the member cannot be changed to a preferred medication within the same class due to allergy, drug interaction, clinically significant adverse event,

OR member is established on current therapy with prior payer (i.e. Commercial, Fee-for-Service, Managed Care Plan, etc);

16. For Pegylated Interferons: Documentation that the member will be monitored closely with periodic clinical and laboratory evaluations.
17. Only regimens listed as recommended or alternative by the American Association for the Study of Liver Diseases (AASLD) will be approved with duration of approval based upon guidelines. See section V. Dosage and Administration.

Approval duration: 84 days.

B. Other diagnoses/indications:

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Chronic Hepatitis C Infection (must meet all)**:**

1. Currently receiving medication via prior payer (i.e. Commercial, Fee-for-Service, Managed Care Plan, etc.) or member has previously met initial approval criteria;
2. HCV RNA testing is done every 28 days.
3. Only regimens listed as recommended or alternative by the American Association for the Study of Liver Diseases (AASLD) will be approved with duration of approval based upon guidelines. See section V. Dosage and Administration.

Approval duration: 84 days.

B. Other diagnoses/indications:

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AASLD: American Association for the Study of Liver Diseases
APRI: AST to platelet ratio
DAA: Direct Acting Antiviral
FDA: Food and Drug Administration
FIB-4: Fibrosis-4 index
HBV: hepatitis B virus
HCC: hepatocellular carcinoma
HCV: hepatitis C virus
HIV: human immunodeficiency virus
IDSA: Infectious Diseases Society of America
IQR: interquartile range
MRE: magnetic resonance elastography
NS3/4A, NS5A/B: nonstructural protein
PegIFN: pegylated interferon
RBV: ribavirin
RNA: ribonucleic acid

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Mavyret™ (glecaprevir /pibrentasvir)	Treatment-naïve chronic HCV infection without cirrhosis or with compensated cirrhosis (Child-Pugh A): **Genotypes 1, 2, 3, 4, 5, or 6** Three tablets PO QD for 8 weeks	Mavyret: glecaprevir 300 mg/pibrentasvir 120 mg (3 tablets) per day
Mavyret™ (glecaprevir /pibrentasvir)	Treatment-experienced with IFN/pegIFN + RBV +/- sofosbuvir chronic HCV infection: **Genotypes 1, 2, 4, 5, or 6** Without cirrhosis: Three tablets PO QD for 8 weeks With compensated cirrhosis: Three tablets PO QD for 12 weeks	Mavyret: glecaprevir 300 mg/pibrentasvir 120 mg (3 tablets) per day
Mavyret™ (glecaprevir /pibrentasvir)	Treatment-experienced with IFN/pegIFN + RBV +/- sofosbuvir chronic HCV infection: **Genotype 3** Three tablets PO QD for 16 weeks	Mavyret: glecaprevir 300 mg/pibrentasvir 120 mg (3 tablets) per day
Mavyret™ (glecaprevir /pibrentasvir)	Treatment-experienced with NS5A inhibitor without prior NS3/4A protease inhibitor chronic HCV infection: **Genotype 1** Without cirrhosis or with compensated cirrhosis: Three tablets PO QD for 16 weeks	Mavyret: glecaprevir 300 mg/pibrentasvir 120 mg (3 tablets) per day
Mavyret™ (glecaprevir /pibrentasvir)	Treatment-experienced with NS3/4A protease inhibitor without prior NS5A inhibitor chronic HCV infection: **Genotype 1**	Mavyret: glecaprevir 300 mg/pibrentasvir 120 mg (3 tablets) per day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	Without cirrhosis or with compensated cirrhosis: Three tablets PO QD for 12 weeks	
sofosbuvir/velpatasvir (Epclusa) [labeler 72626]	Chronic HCV without cirrhosis or with compensated cirrhosis (Child-Pugh A): **Genotypes 1, 2, 3, 4, 5, or 6** One tablet PO QD for 12 weeks	Epclusa: sofosbuvir 400 mg/velpatasvir 100 mg (1 tablet) per day
sofosbuvir/velpatasvir (Epclusa) [labeler 72626]	Chronic HCV with decompensated cirrhosis (Child-Pugh B or C): **Genotypes 1, 2, 3, 4, 5, or 6** Ribavirin eligible: One tablet PO QD plus ribavirin for 12 weeks Ribavirin ineligible (off-label): One tablet PO QD for 24 weeks	Epclusa: sofosbuvir 400 mg/velpatasvir 100 mg (1 tablet) per day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications

- If used in combination with RBV, all contraindications to RBV also apply to Harvoni combination therapy.

Appendix D: Approximate Scoring Equivalencies using METAVIR F3/F4 as Reference

Fibrosis/ Cirrhosis	Serologic Tests*				Radiologic Tests†		Liver Biopsy‡	
	Fibro Test	FIBRO Spect II	APRI	FIB-4	FibroScan (kPa)	MRE (kPa)	METAVIR	Ishak
Advanced fibrosis	≥0.59	≥42	>1.5	>3.25	≥9.5	≥4.11	F3	F4-5
Cirrhosis	≥0.75	≥42	>1.5	>3.25	≥12.0	≥4.71	F4	F5-6

*Serologic tests:
FibroTest (available through Quest as FibroTest or LabCorp as FibroSure)
FIBROSpect II (available through Prometheus Laboratory)
APRI (AST to platelet ratio index)
FIB-4 (Fibrosis-4 index: includes age, AST level, platelet count)
†Radiologic tests:
FibroScan (transient elastography)
MRE (magnetic resonance elastography)
‡Liver biopsy (histologic scoring systems):
METAVIR F3/F4 is equivalent to Knodell, Scheuer, and Batts-Ludwig F3/F4 and Ishak F4-5/F5-6
METAVIR fibrosis stages: F0 = no fibrosis; F1 = portal fibrosis without septa; F2 = few septa; F3 = numerous septa without cirrhosis; F4 = cirrhosis

Appendix E: Direct-Acting Antivirals for Treatment of HCV Infection

Brand Name	Drug Class				
	NS5A Inhibitor	Nucleotide Analog NS5B Polymerase Inhibitor	Non-Nucleoside NS5B Palm Polymerase Inhibitor	NS3/4A Protease Inhibitor (PI)	CYP3A Inhibitor
Daklinza	Daclatasvir				
Epclusa*	Velpatasvir	Sofosbuvir			
Harvoni*	Ledipasvir	Sofosbuvir			
Mavyret*	Pibrentasvir			Glecaprevir	
Olysio				Simeprevir	
Sovaldi		Sofosbuvir			
Technivie*	Ombitasvir			Paritaprevir	Ritonavir
Viekira XR/PAK*	Ombitasvir		Dasabuvir	Paritaprevir	Ritonavir
Vosevi*	Velpatasvir	Sofosbuvir		Voxilaprevir	
Zepatier*	Elbasvir			Grazoprevir	

*Combination drugs

Appendix F: General Information

- Hepatitis B Virus Reactivation (HBV) is a Black Box Warning for all direct-acting antiviral drugs for the treatment of HCV. HBV reactivation has been reported when treating HCV for members co-infected with HBV. Members should be monitored for HBV reactivation & hepatitis flare during HCV treatment and post-treatment follow-up.
- Treatment with Harvoni for 8 weeks can be considered in treatment-naïve members without cirrhosis who have pre-treatment HCV RNA less than 6 million IU/mL. In the ION-3 trial, members with a baseline HCV viral load of < 6 million IU/mL and were treated with Harvoni for 8 weeks achieved SVR-12 at a rate of 97% versus 96% of those treated with Harvoni for 12 weeks.
- Child-Pugh Score

	1 Point	2 Points	3 Points
Bilirubin	Less than 2 mg/dL Less than 34 umol/L	2-3 mg/dL 34-50 umol/L	Over 3 mg/dL Over 50 umol/L
Albumin	Over 3.5 g/dL Over 35 g/L	2.8-3.5 g/dL 28-35 g/L	Less than 2.8 g/dL Less than 28 g/L
INR	Less than 1.7	1.7 - 2.2	Over 2.2
Ascites	None	Mild / medically controlled	Moderate-severe / poorly controlled
Encephalopathy	None	Mild / medically controlled	Moderate-severe / poorly controlled.

	1 Point	2 Points	3 Points
		Grade I-II	Grade III-IV

Child-Pugh class is determined by the total number of points: A = 5-6 points; B = 7-9 points; C = 10-15 points

- Acceptable medical justification for inability to use Mavyret (preferred product):
  - Severe hepatic disease (Child-Pugh C): use of Mavyret is not recommended due to higher exposures of glecaprevir and pibrentasvir.
  - Moderate hepatic disease (Child-Pugh B): although not an absolute contraindication, use of Mavyret is not recommended in members with moderate hepatic disease (Child-Pugh B) due to lack of safety and efficacy data.
    - Following administration of Mavyret in HCV infected subjects with *compensated* cirrhosis (Child-Pugh A), exposure of glecaprevir was approximately 2-fold and pibrentasvir exposure was similar to non-cirrhotic *HCV infected* subjects.
    - At the clinical dose, compared to *non-HCV infected* subjects with *normal hepatic function*, glecaprevir AUC was 100% higher in Child-Pugh B subjects, and increased to 11-fold in Child-Pugh C subjects. Pibrentasvir AUC was 26% higher in Child-Pugh B subjects, and 114% higher in Child-Pugh C subjects.
  - Drug-drug interactions with one or more the following agents:
    - Atazanavir
    - Efavirenz
- Unacceptable medical justification for inability to use Mavyret (preferred product):
  - Black Box Warning (BBW): currently or previously infected with hepatitis B virus. This BBW is not unique to Mavyret, and it applies across the entire therapeutic class of direct-acting antivirals for treatment of HCV infection. Therefore it is not a valid clinical reason not to use Mavyret.
  - Concurrent anticoagulant therapy: Fluctuations in International Normalized Ratio (INR) have been observed in warfarin recipients who were also receiving treatment for HCV infections. This BBW is not unique to Mavyret, and it applies across the entire therapeutic class of direct-acting antivirals for treatment of HCV infection. Although caution is advised when using Mavyret while receiving concurrent anticoagulant therapy, specifically warfarin, this is not an absolute contraindication as long as member is adequately monitored and educated during therapy.
  - Drug-drug interactions with one or more of the following agents:
    - Rifampin, carbamazepine, or St. John's wort:
    - These drug-drug interactions are not unique to Mavyret, and they apply across the entire therapeutic class of direct-acting antivirals for treatment of HCV infection.

V. Dosage and Administration

Indication: Adult patients with chronic HCV infection			
Indication	**Dosing Regimen**	**Maximum Dose**	**Reference**
Genotype 1 chronic HCV infection:	One tablet PO QD for:	One tablet (sofosbuvir 400 mg /	1) FDA-approved labeling

Indication: Adult patients with chronic HCV infection			
Indication	**Dosing Regimen**	**Maximum Dose**	**Reference**
	Treatment-naïve adult patients without cirrhosis AND whose HCV viral load is less than 6 million IU/mL: for 8 weeks ǂ Treatment-naïve non-black, HIV-uninfected adult patients without cirrhosis AND whose HCV viral load is greater than or equal to 6 million IU/mL: for 12 weeks Treatment-naïve adult patients with compensated cirrhosis: for 12 weeks Treatment-experienced with pegIFN/ RBV adult patients without cirrhosis: for 12 weeks Treatment-experienced with pegIFN/ RBV adult patients with compensated cirrhosis: Harvoni plus weight-based RBV[ǂ] for 12 weeks Treatment-experienced with NS3 PI*/pegIFN/RBV adult patient without cirrhosis for 12 weeks Treatment-experienced with NS3 PI*+/- pegIFN/RBV adult patients with compensated cirrhosis: Harvoni plus weight-based RBV for 12 weeks Treatment-experienced with Sofosbuvir (but not with simeprevir) without cirrhosis: Harvoni plus weight-based RBV for 12 weeks	ledipasvir 90 mg) per day	2) AASLD-IDSA (updated September 2017)
Genotype 1, 4[ǂ], 5[ǂ], or 6[ǂ] with decompensated cirrhosis: Adult patients who may or may not be candidates for liver transplantation, including those with hepatocellular carcinoma	One tablet PO QD plus low initial dose of RBV (600 mg, increased as tolerated) for 12 weeks Or without RBV for 24 weeks if RBV ineligible	One tablet (sofosbuvir 400 mg / ledipasvir 90 mg) per day	1) FDA-approved labeling 2) AASLD-IDSA (updated September 2017)

Indication: Adult patients with chronic HCV infection			
Indication	**Dosing Regimen**	**Maximum Dose**	**Reference**
Genotype 1, 4, 5, or 6 with decompensated cirrhosis: Adult patients in whom a previous sofosbuvir-containing regimen has failed‡	One tablet PO QD with low initial dose of RBV (600 mg, increased as tolerated) for 24 weeks	One tablet (sofosbuvir 400 mg / ledipasvir 90 mg) per day	AASLD-IDSA (updated Sept. 2017)
Genotype 1 or 4 post-liver transplantation: Treatment-naive and treatment-experienced adult patients without cirrhosis, with compensated cirrhosis, or with decompensated cirrhosis	One tablet PO QD plus RBV for 12 weeks	One tablet (sofosbuvir 400 mg / ledipasvir 90 mg) per day	1) FDA-approved labeling 2) AASLD-IDSA (updated September 2017)
Genotype 4, 5, or 6: Treatment-naive adult patients with or without compensated cirrhosis	One tablet PO QD for 12 weeks	One tablet (sofosbuvir 400 mg / ledipasvir 90 mg) per day	1) FDA-approved labeling 2) AASLD-IDSA (updated September 2017)
Genotype 4: Treatment-experienced** adult patients without compensated cirrhosis	One tablet PO QD for 12 weeks	One tablet (sofosbuvir 400 mg / ledipasvir 90 mg) per day	1) FDA-approved labeling 2) AASLD-IDSA (updated September 2017)
Genotype 4: Treatment-experienced** adult patients with compensated cirrhosis	One tablet PO QD plus weight-based RBV for 12 weeks	One tablet (sofosbuvir 400 mg / ledipasvir 90 mg) per day	1) FDA-approved labeling 2) AASLD-IDSA (updated September 2017)
Genotype 5 or 6: Treatment-experienced** adult patients with or without compensated cirrhosis	One tablet PO QD for 12 weeks	One tablet (sofosbuvir 400 mg / ledipasvir 90 mg) per day	1) FDA-approved labeling 2) AASLD-IDSA (updated September 2017)

AASLD/IDSA treatment guidelines for chronic hepatitis C infection are updated at irregular intervals; refer to the most updated AASLD/IDSA guideline for most accurate treatment regimen.
** NS3 protease inhibitor = telaprevir, boceprevir, or simeprevir*
*** Treatment-experienced refers to previous treatment with peginterferon/RBV unless otherwise stated*
ǂ Off-label, AASLD-IDSA guideline-supported dosing regimen

Indication: Pediatric patients (age ≥ 12 years or weighing at least 35 kg) with chronic HCV infection			
Indication	**Dosing Regimen**	**Maximum Dose**	**Reference**
Genotype 1 chronic HCV infection	One tablet PO QD for: Treatment naïve pediatric patients (≥ 3 years and ≥ 35 kg) without cirrhosis or with compensated cirrhosis regardless of baseline viral load: for 12 weeks Treatment-experienced with pegIFN/RBV pediatric (≥ 3 years and ≥ 35 kg) without cirrhosis: for 12 weeks Treatment-experienced pediatric patients (≥ 3 years and ≥ 35 kg) with compensated cirrhosis: for 24 weeks	One tablet (sofosbuvir 400 mg / ledipasvir 90 mg) per day	FDA-approved labeling
Genotype 4, 5, or 6 chronic HCV infection	Treatment-naive or treatment-experienced pediatric (≥ 3 years and ≥ 35 kg) patients with or without compensated cirrhosis: One tablet PO QD for 12 weeks	One tablet (sofosbuvir 400 mg / ledipasvir 90 mg) per day	FDA-approved labeling

VI. Product Availability

Drug Name	Availability
Epclusa	Tablets: 400 mg-100 mg
Harvoni	Tablets: 45 mg-200 mg, 90 mg-400 mg
Ledipasvir/Sofosbuvir	Tablets: 90 mg-400 mg
Mavyret	Tablets: 100 mg-40 mg
Pegasys	Solution for injection: 180 mcg/0.5 mL, 180 mcg/mL
PegIntron	Solution for injection: 50 mcg, 80 mcg, 120 mcg, 150 mcg
Rebetol	Capsules: 200 mg
RibaPak	Compliance pack tablets: 800 mg/day, 1000 mg/day, 1200 mg/day
Ribasphere	Capsules: 200 mg
Ribasphere	Tablets: 200 mg, 400 mg, 600 mg
Ribasphere RibaPak	Dose pack tablets: 600 mg/day
RibaTab	Compliance pack tablets: 800 mg/day, 1000 mg/day, 1200 mg/day
Ribavirin	Capsules: 200 mg
Ribavirin	Tablets: 200 mg

Drug Name	Availability
Sofosbuvir/Velpatasvir	Tablets: 400 mg-100 mg
Sovaldi	Tablets: 400 mg
Sylatron	Solution for injection: 200 mcg, 300 mcg, 600 mcg
Victrelis	Capsules: 200 mg
Viekira Pak	Tablets: 14 each Dasabuvir 250mg, 14 each Ombitasvir 12.5mg, Paritaprevir 75mg, Ritonavir 50mg
Vosevi	Tablets: 400 mg-100 mg-100 mg
Zepatier	Tablets: 50 mg-100 mg

VII. References

1. Harvoni Prescribing Information. Foster City, CA: Gilead Sciences, Inc.; November 2017. Available at http://www.harvoni.com. Accessed May 1, 2019.
2. American Association for the Study of Liver Diseases/ Infectious Disease Society of America (AASLD-IDSA). HCV guidance: recommendations for testing, managing, and treating hepatitis C. Last updated May 24 2018. Available at: https://www.hcvguidelines.org/. Accessed May 1, 2019.
3. Centers for Disease Control and Prevention. HIV and viral hepatitis: fact sheet. June 2017. Available at: https://www.cdc.gov/hiv/pdf/library/factsheets/hiv-viral-hepatitis.pdf. Accessed May 1, 2019.
4. Wirth S, Gonzalez-Peralta R, Rosenthal P, et al. Sofosbuvir-Containing Regimens are Safe and Effective in Adolescents with Chronic hepatitis C Infection. The 26th Annual Meeting of the Asian pacific Association for the Study of the Liver (APASL) in February 15-19, 2017 in Shanghai, China.
5. Squires JE, Balisteri WF. Hepatitis C Virus Infection in Children and Adolescents. Hepatology Communications 2017; 1(2): 87-98.
6. Platt L, Easterbrook P, Gower E, et al. Prevalence and burden of HCV co-infection in people living with HIV: a global systematic review and meta-analysis. Lanet Infect Dis 2016;16:797-808. http://dx.doi.org/10.1016/

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy created.	10.19	N/A
Added statement regarding approved dosing regimens to Initial and Continued Approval Criteria: Only regimens listed as recommended or alternative by the American Association for the Study of Liver Diseases (AASLD) will be approved with duration of approval based upon guidelines. See section V. Dosage and Administration; removed statement requiring documentation that member has had no abuse of alchohol and drugs for the previous 6 months.	03.20	N/A
Added generic Epclusa to PA required, preferred list; added Zepatier to PA required, non-preferred list	10.20	N/A

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.