Clinical Policy: Sofosbuvir/Velpatasvir (Epclusa)
Reference Number: OH.PHAR.PPA.05
Effective Date: 01.19
Last Review Date: 12.18
Line of Business: Medicaid

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

Description
Sofosbuvir/velpatasvir (Epclusa®) is a fixed-dose combination of sofosbuvir, a hepatitis C virus (HCV) nucleotide analog NS5B polymerase inhibitor, and velpatasvir, an HCV NS5A inhibitor.

FDA Approved Indication(s)
Epclusa is indicated for the treatment of adult patients with chronic HCV genotype 1, 2, 3, 4, 5, or 6 infection:
- Without cirrhosis or with compensated cirrhosis
- With decompensated cirrhosis for use in combination with ribavirin (RBV)

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 health plans affiliated with Centene Corporation® that Epclusa is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Chronic Hepatitis C Infection (must meet all):
      1. Diagnosis of chronic HCV infection as evidenced by detectable serum HCV RNA levels by quantitative assay in the last 90 days;
      2. Confirmed HCV genotype is 1, 2, 3, 4, 5 or 6;
         *Chart note documentation and copies of lab results are required
      3. Documentation of the treatment status of the patient (treatment-naive or treatment-experienced);
      4. Documentation of cirrhosis status of the patient (no cirrhosis, compensated cirrhosis, or decompensated cirrhosis);
      5. Prescribed by, or in consultation with, a gastroenterologist, hepatologist, infectious disease specialist or other hepatitis specialist. Consult must be within the past year with documentation of recommended regimen;
      6. Age ≥ 18 years;
      7. Member has at least one of the following contraindications to Mavyret (a or b):
         a. Decompensated cirrhosis (Child-Pugh B or C) confirmed by lab findings and clinical notes;
         b. Receiving treatment with efavirenz or atazanavir;
         *See Appendix F for additional details on acceptable contraindications
      8. Member does not have limited life expectancy (less than 12 months) due to non-liver-related comorbid conditions
9. Documentation in provider notes (must be submitted) showing that member has had no abuse of alcohol and drugs for the previous 6 months. MUST submit urine drug screen for members with history of abuse of drugs other than alcohol. Counseling MUST be provided and documented regarding non-abuse of alcohol and drugs as well as education on how to prevent HCV transmission;

10. Documentation of Metavir Fibrosis score, documentation of the method used and date fibrosis score was obtained;

11. Member is not receiving dialysis and has CrCl >30mL/min; verified by lab results including a creatinine level within the past 6 months;

12. 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 during treatment or within 6 months of stopping;
   b. Agreement that member and their partner(s) will use two forms of effective contraception during treatment and for at least 6 months after stopping;
   c. Verification that monthly pregnancy tests will be performed throughout treatment;
   d. Members with CrCl <50 ml/min (moderate or severe renal dysfunction, ESRD, HD) should have dosage reduced;
   e. At the time of request, member does NOT meet any of the following:
      1) History of severe or unstable cardiac disease
      2) Diagnosis of hemoglobinopathy (e.g., thalassemia major, sickle cell anemia)
      3) Hypersensitivity to ribavirin
      4) Baseline platelet count <70,000 cells/mm3
      5) ANC <1500 cells/mm3
      6) Hb <12 g/dl in women or <13 g/dl in men

13. Prescriber has discussed the importance of adherence to office visits, lab testing, imaging, procedures and to taking requested regimen as prescribed. Prescriber attests that member will be adherent to treatment plan.

14. Prescribed regimen is consistent with an FDA or AASLD-IDSA recommended regimen (see Section V Dosage and Administration for reference);

15. Dose does not exceed sofosbuvir/velpatasvir 400 mg/100 mg (1 tablet) per day.

Approval duration: up to a total of 24 weeks*
(*Approved duration should be consistent with a regimen in Section V Dosage and Administration)

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. Member meets one of the following (a or b):
      a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
b. Documentation supports that member is currently receiving Epclusa for chronic HCV infection and has recently completed at least 60 days of treatment with Epclusa;
2. Member is responding positively to therapy;
3. Dose does not exceed sofosbuvir/velpatasvir 400mg/100mg (1 tablet) per day.

**Approval duration: up to a total of 24 weeks**
(*Approved duration should be consistent with a regimen in Section V Dosage and Administration)

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 policies – 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
- 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.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
</table>
| **Mavyret™ (glecaprevir/pibrentasvir)** | Treatment-naïve chronic HCV infection: **Genotypes 1, 2, 3, 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™** | Treatment-experienced with IFN/pegIFN + RBV +/- sofosbuvir chronic HCV infection: | Mavyret: glecaprevir 300 |
## Sofosbuvir/Velpatasvir

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
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</tr>
</thead>
</table>
| (glecaprevir/pibrentasvir) | **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 | mg/pibrentasvir 120 mg (3 tablets) per day |
| Mavyret™ (glecaprevir/pibrentasvir) | Treatment-experienced with IFN/pegIFN + RBV +/- sofosbuvir chronic HCV infection: **Genotype 3**  
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 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**  
Without cirrhosis or with compensated cirrhosis: Three tablets PO QD for 12 weeks | Mavyret: glecaprevir 300 mg/pibrentasvir 120 mg (3 tablets) per day |

**Appendix C: Contraindications**

- Epclusa and RBV combination regimen is contraindicated in patients for whom RBV is contraindicated. Refer to the RBV prescribing information for a list of contraindications for RBV.

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

<table>
<thead>
<tr>
<th>Fibrosis/Cirrhosis</th>
<th>Serologic Tests*</th>
<th>Radiologic Tests†</th>
<th>Liver Biopsy‡</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FibroTest</td>
<td>FIBRO Spect II</td>
<td>APRI</td>
</tr>
<tr>
<td>Advanced fibrosis</td>
<td>≥0.59</td>
<td>≥42</td>
<td>&gt;1.5</td>
</tr>
<tr>
<td>Cirrhosis</td>
<td>≥0.75</td>
<td>≥42</td>
<td>&gt;1.5</td>
</tr>
</tbody>
</table>

*Serologic tests:
  
  FibroTest (available through Quest as FibroTest or LabCorp as FibroSure)  
  FIBRO Spect 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

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Drug Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daklinza</td>
<td>Daclatasvir</td>
</tr>
<tr>
<td>Epclusa*</td>
<td>Velpatasvir Sofosbuvir</td>
</tr>
<tr>
<td>Harvoni*</td>
<td>Ledipasvir Sofosbuvir</td>
</tr>
<tr>
<td>Mavyret*</td>
<td>Pibrentasvir Glecaprevir</td>
</tr>
<tr>
<td>Olysio</td>
<td>Simeprevir</td>
</tr>
<tr>
<td>Sovaldi</td>
<td>Sofosbuvir</td>
</tr>
<tr>
<td>Technivie*</td>
<td>Ombitasvir Paritaprevir Ritonavir</td>
</tr>
<tr>
<td>Viekira XR/PAK*</td>
<td>Ombitasvir Dasabuvir Paritaprevir Ritonavir</td>
</tr>
<tr>
<td>Vosevi*</td>
<td>Velpatasvir Sofosbuvir Voxilaprevir</td>
</tr>
<tr>
<td>Zepatier*</td>
<td>Elbasvir Grazoprevir</td>
</tr>
</tbody>
</table>

*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 patients co-infected with HBV, leading to fulminant hepatitis, hepatic failure, and death, in some cases. Patients should be monitored for HBV reactivation and hepatitis flare during HCV treatment and post-treatment follow-up, with treatment of HBV infection as clinically indicated.

- 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 patients 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 patient 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

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genotype 1-6: Without cirrhosis or with compensated cirrhosis, treatment-naïve or pegIFN/RBV-experienced patient</td>
<td>One tablet PO QD for 12 weeks (GT 3 with compensated cirrhosis for pegIFN/RBV-experienced patient may use: one tablet PO QD with weight-based RBV for 12 weeks) †</td>
<td>One tablet (sofosbuvir 400 mg /velpatasvir 100 mg) per day</td>
<td>1) FDA-approved labeling 2) AASLD-IDSA (updated September 2017)</td>
</tr>
<tr>
<td>Genotype 1-6: With decompensated cirrhosis treatment-naïve or treatment-experienced* patient</td>
<td>One tablet PO QD with weight-based RBV for 12 weeks (GT 1, 4, 5, or 6 with decompensated cirrhosis and RBV-ineligible may use: one tablet PO QD for 24 weeks) ‡</td>
<td>One tablet (sofosbuvir 400mg /velpatasvir 100 mg) per day</td>
<td>1) FDA-approved labeling 2) AASLD-IDSA (updated September 2017)</td>
</tr>
<tr>
<td>Indication</td>
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<td>Reference</td>
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</tr>
<tr>
<td>Genotype 1-6: With decompensated cirrhosis in whom prior sofosbuvir- or NS5A-based treatment experienced failed</td>
<td>One tablet PO QD with weight-based RBV for 24 weeks</td>
<td>One tablet (sofosbuvir 400mg /velpatasvir 100 mg) per day</td>
<td>AASLD-IDSA (updated September 2017)</td>
</tr>
<tr>
<td>Genotype 1b: With compensated cirrhosis or without cirrhosis and non-NS5A inhibitor, sofosbuvir-containing regimen-experienced</td>
<td>One tablet PO QD for 12 weeks</td>
<td>One tablet (sofosbuvir 400mg /velpatasvir 100 mg) per day</td>
<td>AASLD-IDSA (updated September 2017)</td>
</tr>
<tr>
<td>Genotype 2: With or without compensated cirrhosis, sofosbuvir + RBV-experienced</td>
<td>One tablet PO QD for 12 weeks</td>
<td>One tablet (sofosbuvir 400mg /velpatasvir 100 mg) per day</td>
<td>AASLD-IDSA (updated September 2017)</td>
</tr>
<tr>
<td>Genotype 2 or 3: Treatment-naïve and treatment-experienced patients, post-liver transplant with compensated cirrhosis or decompensated cirrhosis</td>
<td>One tablet PO QD with weight-based RBV for 12 weeks</td>
<td>One tablet (sofosbuvir 400mg /velpatasvir 100 mg) per day</td>
<td>AASLD-IDSA (updated September 2017)</td>
</tr>
<tr>
<td>Genotype 3 with NS5A Y93H polymorphism: Treatment-naïve with cirrhosis or treatment-experienced* patient</td>
<td>One tablet PO QD with weight-based RBV for 12 weeks</td>
<td>One tablet (sofosbuvir 400mg /velpatasvir 100 mg) per day</td>
<td>AASLD-IDSA (updated September 2017)</td>
</tr>
</tbody>
</table>

*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.

*Treatment-experienced refers to previous treatment with NS3 protease inhibitor (telaprevir, boceprevir, or simeprevir) and/or peginterferon/RBV unless otherwise stated

† Off-label, AASLD-IDSA guideline-supported dosing regimen

**VI. Product Availability**

Tablet: sofosbuvir 400 mg with velpatasvir 100 mg
VII. References


<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>New policy created.</td>
<td>12.18</td>
<td>N/A</td>
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</table>

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.

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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.

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