Clinical Policy: Glecaprevir/Pibrentasvir (Mavyret)

Reference Number: CP.CPA.285
Effective Date: 08.15.17
Last Review Date: 08.24
Line of Business: Commercial

Revision Log

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

Description

Glecaprevir and pibrentasvir (Mavyret®) are a fixed-dose combination of glecaprevir, a hepatitis C virus (HCV) NS3/4A protease inhibitor, and pibrentasvir, an HCV NS5A inhibitor.

FDA Approved Indication(s)

Mavyret is indicated for the treatment of adult and pediatric patients 3 years and older with:

- Chronic HCV genotype 1, 2, 3, 4, 5, or 6 infection without cirrhosis or with compensated cirrhosis (Child-Pugh A).
- HCV 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.

* In clinical trials, prior NS5A inhibitor experience included ledipasvir and sofosbuvir or daclatasvir with pegylated interferon and ribavirin.
** In clinical trials, prior NS3/4A protease inhibitor experience included regimens containing simeprevir and sofosbuvir, or simeprevir, boceprevir, or telaprevir with pegylated interferon and ribavirin.

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 Mavyret is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

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

1. Diagnosis of HCV infection as evidenced by detectable serum HCV RNA levels by quantitative assay in the last 6 months;
2. Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious disease specialist, or provider who has expertise in treating HCV based on a certified training program (*see Appendix F*);
3. Age ≥ 3 years;
4. Member meets one of the following (a or b):
   a. Member is treatment-naïve and has either compensated cirrhosis or no cirrhosis (i.e., eligible for simplified treatment regimen);*
   b. Confirmed HCV genotype is one of the following (i, ii, iii, or iv):*
      i. For treatment-naïve patients: genotypes 1, 2, 3, 4, 5, or 6;

ii. For members treatment-experienced with interferon (IFN)/pegylated-interferon (pegIFN), ribavirin (RBV), and/or sofosbuvir only: genotypes 1, 2, 3, 4, 5, or 6;
iii. For members treatment-experienced with either an NS5A inhibitor or an NS3/4A protease inhibitor: genotype 1 (*see Appendix D*);
iv. For Vosevi®- or Mavyret-experienced members: genotype 1, 2, 3, 4, 5, or 6;

**Chart note documentation and copies of lab results are required*

5. If cirrhosis is present, confirmation of Child-Pugh A status;
6. Member is not treatment-experienced with both NS3/4A protease inhibitor AND NS5A inhibitors, such as combination therapies including Technivie™, Viekira®, and Zepatier®;
7. Member must use **brand Epclusa®** or **Vosevi**, unless clinically significant adverse effects are experienced or both are contraindicated;
   **Coadministration with omeprazole up to 20 mg is not considered an acceptable medical justification for inability to use for Epclusa*
8. Life expectancy ≥ 12 months with HCV treatment;
9. Prescribed regimen is consistent with an FDA or AASLD-IDSA recommended regimen (*see Section V Dosage and Administration for reference)*;
10. Dose does not exceed one of the following (a, b, c, or d):
    a. Adult and pediatric members 12 years of age and older or with body weight ≥ 45 kg: glecaprevir 300 mg and pibrentasvir 120 mg (3 tablets) per day;
    b. Pediatric members 3 years to < 12 years of age with body weight < 20 kg: glecaprevir 150 mg and pibrentasvir 60 mg per day;
    c. Pediatric members 3 years to < 12 years of age with body weight 20 kg to < 30 kg: glecaprevir 200 mg and pibrentasvir 80 mg per day;
    d. Pediatric members 3 years to < 12 years of age with body weight 30 kg to < 45 kg: glecaprevir 250 mg and pibrentasvir 100 mg per day.

Approval duration: up to a total of 16 weeks*
*(*Approved duration should be consistent with a regimen in Section V Dosage and Administration)*

B. Other diagnoses/indications (must meet all):

1. Member must use **brand Epclusa** or **Vosevi**, if applicable for the requested indication, unless clinically significant adverse effects are experienced or both are contraindicated;
2. One of the following (a or b):
   a. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (i or ii):
      i. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial; or
      ii. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial; or
   b. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT

authorized) AND criterion 2a above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial.

II. Continued Therapy

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

1. Member meets one of the following (a, b or c):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
   c. Must meet both of the following (i and ii):
      i. Documentation supports that member is currently receiving Mavyret for HCV infection and has recently completed at least 40 days of treatment with Mavyret;
      ii. Confirmed HCV genotype is one of the following (1, 2, 3, or 4);
         1) For treatment-naïve members: genotypes 1, 2, 3, 4, 5, or 6;
         2) For members treatment-experienced with IFN/pegIFN, RBV, and/or sofosbuvir only: genotypes 1, 2, 3, 4, 5, or 6;
         3) For members treatment-experienced with either an NS5A inhibitor or an NS3/4A protease inhibitor: genotype 1 (*see Appendix E*);
         4) For Vosevi- experienced members: genotype 1, 2, 3, 4, 5, or 6;
2. Member is not treatment-experienced with both NS3/4A protease inhibitor AND NS5A inhibitors, such as combination therapies including Technivie, Viekira, and Zepatier;
3. Member is responding positively to therapy;
4. Dose does not exceed one of the following (a, b, c, or d):
   a. Adult and pediatric members 12 years of age and older or with body weight ≥ 45 kg: glecaprevir 300 mg and pibrentasvir 120 mg (3 tablets) per day;
   b. Pediatric members 3 years to < 12 years of age with body weight < 20 kg: glecaprevir 150 mg and pibrentasvir 60 mg per day;
   c. Pediatric members 3 years to < 12 years of age with body weight 20 kg to < 30 kg: glecaprevir 200 mg and pibrentasvir 80 mg per day;
   d. Pediatric members 3 years to < 12 years of age with body weight 30 kg to < 45 kg: glecaprevir 250 mg and pibrentasvir 100 mg per day.

Approval duration: up to a total of 16 weeks*

*(*Approved duration should be consistent with a regimen in Section V Dosage and Administration)*

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial; or

b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial.

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.CPA.09 for commercial or evidence of coverage documents;

B. Treatment-experienced patients with both NS3/4A protease inhibitor AND NS5A inhibitor, such as combination therapies including: Technivie, Viekira, and Zepatier.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AASLD: American Association for the Study of Liver Diseases
DAA: direct-acting antiviral
FDA: Food and Drug Administration
HBV: hepatitis B virus
HCV: hepatitis C virus
HIV: human immunodeficiency virus
IDSA: Infectious Diseases Society of America
NS3/4A, NS5A/B: nonstructural protein
PegIFN: pegylated interferon
RBV: ribavirin
RNA: ribonucleic acid
SVR12: sustained virologic response at 12 weeks

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
sofosbuvir/velpatasvir (Epclusa®)	**Genotypes 1 through 6** Without cirrhosis or with compensated cirrhosis, treatment naïve or NS3/4A protease inhibitor and/or pegIFN/ RBV-experienced: One tablet PO QD for 12 weeks	sofosbuvir 400 mg/ velpatasvir 100 mg (1 tablet) per day
sofosbuvir/velpatasvir (Epclusa®)	**Genotypes 1 through 6** Treatment-naïve and treatment-experienced patients, post-liver transplant with compensated cirrhosis or without cirrhosis: One tablet PO QD for 12 weeks	sofosbuvir 400 mg/ velpatasvir 100 mg (1 tablet) per day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
sofosbuvir/velpatasvir (Epclusa®) + RBV	**Genotype 3 with NS5A Y93H polymorphism** Treatment-naïve with compensated cirrhosis or treatment-experienced without cirrhosis patient: sofosbuvir/velpatasvir 400 mg/100 mg + weight-based RBV for 12 weeks‡	Varies
Vosevi® (sofosbuvir/ velpatasvir/ voxilaprevir)	**Genotype 1-6** Treatment-experienced with NS5A inhibitor* with or without compensated cirrhosis: One tablet PO QD for 12 weeks	One tablet (sofosbuvir 400 mg/ velpatasvir 100 mg/ voxilaprevir 100 mg) per day
Vosevi® (sofosbuvir/ velpatasvir/ voxilaprevir)	**Genotype 1a or 3** Treatment-experienced with a sofosbuvir-containing regimen without NS5A inhibitor with or without compensated cirrhosis: One tablet PO QD for 12 weeks	One tablet (sofosbuvir 400 mg/ velpatasvir 100 mg/ voxilaprevir 100 mg) per day
Vosevi® (sofosbuvir/ velpatasvir/ voxilaprevir) + RBV	**Genotype 1-6** Treatment-experienced with Vosevi with or without compensated cirrhosis: Vosevi one tablet PO QD with weight-based RBV for 24 weeks‡	Varies
Vosevi® (sofosbuvir/ velpatasvir/ voxilaprevir)	**Genotype 1-6** Treatment-experienced with Mavyret without cirrhosis: Vosevi one tablet PO QD for 12 weeks‡	One tablet (sofosbuvir 400 mg/ velpatasvir 100 mg/ voxilaprevir 100 mg) per day
Vosevi® (sofosbuvir/ velpatasvir/ voxilaprevir) + RBV	**Genotype 1-6** Treatment-experienced with Mavyret with compensated cirrhosis: Vosevi one tablet PO QD with weight-based RBV for 12 weeks‡	Varies
Vosevi® (sofosbuvir/ velpatasvir/ voxilaprevir)	**Genotype 3 with NS5A Y93H polymorphism** Treatment-naïve with compensated cirrhosis: One tablet PO QD for 12 weeks‡	One tablet (sofosbuvir 400 mg/ velpatasvir 100 mg/ voxilaprevir 100 mg) 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.
Treatment-experienced refers to previous treatment with NS3 protease inhibitor (telaprevir, boceprevir, or simeprevir) and/or peginterferon/RBV unless otherwise stated.
** In clinical trials, prior NS5A inhibitor experience included daclatasvir, elbasvir, ledipasvir, ombitasvir, or velpatasvir*
ǂ Off-label, AASLD-IDSA guideline-supported dosing regimen

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
  - Patients with severe hepatic impairment (Child-Pugh B or C) or those with any history of prior hepatic decompensation.
  - Co-administration with atazanavir or rifampin.
- Boxed warning(s): risk of hepatitis B virus (HBV) reactivation in patients coinfected with HCV and HBV.

Appendix D: 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
Epclusa*	Velpatasvir	Sofosbuvir			
Harvoni*	Ledipasvir	Sofosbuvir			
Mavyret*	Pibrentasvir			Glecaprevir	
Sovaldi		Sofosbuvir			
Viekira Pak*	Ombitasvir		Dasabuvir	Paritaprevir	Ritonavir
Vosevi*	Velpatasvir	Sofosbuvir		Voxilaprevir	
Zepatier*	Elbasvir			Grazoprevir	

**Combination drugs*

Appendix E: General Information

- Acceptable medical justification for inability to use Epclusa (preferred product):
  - In patients indicated for co-administration of Epclusa with ribavirin: contraindications to ribavirin.
- Unacceptable medical justification for inability to use Epclusa (preferred product):
  - Coadministration with omeprazole up to 20 mg is not considered an acceptable medical justification for inability to use for Epclusa.
    - Per the Epclusa Prescribing Information: "If it is considered medically necessary to coadminister, Epclusa should be administered with food and taken 4 hours before omeprazole 20 mg."

- Acceptable medical justification for inability to use Epclusa or Vosevi (preferred product):
  - In patients indicated for co-administration with amiodarone: serious symptomatic bradycardia in patients taking amiodarone, with cardiac monitoring recommended.
- HBV reactivation 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.
- Due to higher rates of virologic failure and treatment-emergent drug resistance, the data do not support labeling for treatment of HCV genotype 1 infected patients who are both NS3/4A PI and NS5A inhibitor-experienced.
- 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 Grade I-II	Moderate-severe / poorly controlled. 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

- AASLD-IDSA simplified treatment recommendations: In their October 2022 HCV guidance, AASLD-IDSA updated treatment recommendations to recommend two simplified regimens for adults with hepatitis C (*any genotype*) who do not have cirrhosis and have not previously received hepatitis C treatment: either Mavyret x8 weeks or Epclusa x12 weeks. Additionally, for adults with hepatitis C (*any genotype*) who have not previously received hepatitis C treatment and either have compensated cirrhosis or do not have cirrhosis: Mavyret x8 weeks is a recommended regimen. (Epclusa x12 weeks is also an option but would require genotype testing in the compensated cirrhosis setting). With the advent of pangenotypic HCV treatment regimens, HCV genotyping is no longer required prior to treatment initiation for all individuals. In those with evidence of cirrhosis and/or past unsuccessful HCV treatment, treatment regimens may differ by genotype and thus pretreatment genotyping is recommended. For noncirrhotic treatment-naive patients, although genotyping may impact the preferred treatment approach, it is not required if a pangenotypic regimen is used.

Appendix F: Healthcare Provider HCV Training
Acceptable HCV training programs and/or online courses include, but are not limited to the following:

- Hepatitis C online course (https://www.hepatitisc.uw.edu/): University of Washington is funded by the Division of Viral Hepatitis to develop a comprehensive, online self-study course for medical providers on diagnosis, monitoring, and management of hepatitis C virus infection. Free CME and CNE credit available.
- Fundamentals of Liver Disease (https://liverlearning.aasld.org/fundamentals-of-liver-disease): The AASLD, in collaboration with ECHO, the American College of Physicians (ACP), CDC, and the Department of Veterans Affairs, has developed Fundamentals of Liver Disease, a free, online CME course to improve providers' knowledge and clinical skills in hepatology.
- Clinical Care Options: http://www.clinicaloptions.com/hepatitis.aspx
- CDC training resources: https://www.cdc.gov/hepatitis/resources/professionals/trainingresources.htm

Appendix G: Incomplete Adherence and AASLD-IDSA Recommended Management of Treatment Interruptions

- There are minimal data regarding the outcome of patients who have incomplete adherence to direct-acting antiviral (DAA) therapy or the threshold level of adherence below which the incidence of sustained virologic response at 12 weeks (SVR12) is significantly reduced. In general, a treatment interruption of < 7 days is unlikely to impact SVR12.
- There are few data on which to base recommendations regarding how to manage patients who have discontinued DAAs for several days to weeks. The below recommendations are applicable to treatment-naive patients with HCV, without cirrhosis or with compensated cirrhosis*, receiving either Mavyret or Epclusa*. Patients with prior DAA treatment, or receiving other DAA treatment regimens, or other populations (e.g., patients who are posttransplant or have decompensated cirrhosis) should be managed in consultation with an expert.
    - Interruptions during the first 28 days of DAA therapy:
        - If missed ≤ 7 days, restart DAA therapy immediately and complete therapy for originally planned duration (8 or 12 weeks).
        - If missed ≥ 8 days, restart DAA therapy immediately and obtain HCV RNA test as soon as possible. If HCV RNA is negative, complete originally planned DAA treatment course (8 or 12 weeks). Recommendation to extend DAA treatment for an additional 4 weeks for patients with genotype 3 and/or cirrhosis. If HCV RNA is positive or not obtained, extend DAA treatment for an additional 4 weeks.
    - Interruptions after receiving ≥ 28 days of DAA therapy:
        - If missed ≤ 7 days, restart DAA therapy immediately and complete therapy for originally planned duration (8 or 12 weeks).
        - If missed 8-20 consecutive days, restart DAA therapy immediately and obtain HCV RNA test as soon as possible. If HCV RNA is negative, complete originally planned DAA treatment course (8 or 12 weeks). Recommendation to extend DAA treatment for an additional 4 weeks for patients with genotype 3 and/or cirrhosis.

If HCV RNA is positive or not obtained, stop treatment and retreat according to the recommendations in the AASLD-IDSA Retreatment Section.

- If missed ≥ 21 consecutive days, stop DAA treatment and assess for SVR12. If SVR12 not achieved, retreat according to the recommendations in the AASLD-IDSA Retreatment Section.

V. Dosage and Administration

Indication: HCV	Dosing Regimen	Maximum Dose	Reference
Genotypes 1-6: Treatment-naive	Without cirrhosis or with compensated cirrhosis: Three tablets PO QD for 8 weeks	Adults/Peds age ≥ 12 years or with body weight ≥ 45 kg: glecaprevir 300 mg/pibrentasvir 120 mg (3 tablets) per day; Peds age 3 years to < 12 years of age with body weight < 20 kg: glecaprevir 150 mg/pibrentasvir 60 mg per day; Peds age 3 years to < 12 years of age with body weight 20 kg to < 30 kg: glecaprevir 200 mg/pibrentasvir 80 mg per day; Peds age 3 years to < 12 years of age with body weight 30 kg to < 45 kg: glecaprevir 250 mg/pibrentasvir 100 mg per day	FDA-approved labeling
Genotypes 1, 2, 4, 5, or 6: Treatment-experienced with IFN/pegIFN, RBV and/or sofosbuvir	Without cirrhosis: Three tablets PO QD for 8 weeks With compensated cirrhosis: Three tablets PO QD for 12 weeks		
Genotype 3: Treatment-experienced with IFN/pegIFN, RBV and/or sofosbuvir	Without cirrhosis or with compensated cirrhosis: Three tablets PO QD for 16 weeks		
Genotype 1: Treatment-experienced with NS5A inhibitor* without prior NS3/4A protease inhibitor†	Without cirrhosis or with compensated cirrhosis: Three tablets PO QD for 16 weeks		
Genotype 1: Treatment-experienced with NS3/4A protease inhibitor† without prior NS5A inhibitor*	Without cirrhosis or with compensated cirrhosis: Three tablets PO QD for 12 weeks		
Genotype 1-6: Treatment-naïve or treatment-experienced, post-liver or kidney transplantation without cirrhosis or with compensated cirrhosis	Three tablets PO QD for 12 weeks (A 16-week treatment duration is recommended in genotype 1-infected patients who are NS5A inhibitor* experienced without prior treatment with an NS3/4A protease inhibitor† or in genotype		

Indication: HCV	Dosing Regimen	Maximum Dose	Reference
	3-infected patients who are IFN/pegIFN, RBV and/or sofosbuvir treatment-experienced)		
Genotypes 1-6: Patients with prior sofosbuvir/velpatasvir/ voxilaprevir or glecaprevir/pibrentasvir treatment failure	With or without compensated cirrhosis: Mavyret 3 tablets PO QD + Sovaldi 400 mg + weight-based RBV for 16 weeks	Three tablets (glecaprevir 300 mg/pibrentasvir 120 mg) per day	AASLD-IDSA (updated December 2023)

AASLD/IDSA treatment guidelines for hepatitis C infection are updated at irregular intervals; refer to the most updated AASLD/IDSA guideline for most accurate treatment regimen.
** In Mavyret clinical trials, subjects were treated with prior regimens containing ledipasvir and sofosbuvir or daclatasvir with (peg)interferon and RBV*
† In Mavyret clinical trials, subjects were treated with prior regimens containing simeprevir and sofosbuvir, or simeprevir, boceprevir, or telaprevir with (peg)interferon and RBV.

VI. Product Availability

- Tablet: glecaprevir 100 mg and pibrentasvir 40 mg
- Oral pellet: glecaprevir 50 mg and pibrentasvir 20 mg

VII. References

1. Mavyret Prescribing Information. North Chicago, IL: AbbVie Inc.; October 2023. Available at: https://www.rxabbvie.com/pdf/mavyret_pi.pdf Accessed May 7, 2024.
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 December 19, 2023. Available at: https://www.hcvguidelines.org/. Accessed May 20, 2024.
3. CDC. Clinical Overview of Hepatitis C. Last updated November 7, 2023. Available at: https://www.cdc.gov/hepatitis-c/hcp/clinical-overview. Accessed May 20, 2024.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2020 annual review: CP.PCH.18 retired and CP.CPA.285 unretired per June SDC and prior clinical guidance; allowed use in combination with Sovaldi after Vosevi failure; references reviewed and updated.	06.10.20	08.20
Per September SDC and prior clinical guidance for 1/1/21 effective, added redirection to brand Epclusa or Vosevi.	09.22.20	
3Q 2021 annual review: no significant changes; added clarification that redirection to Eplcusa is for brand Epclusa in criteria; included reference to Appendix E with addition of contraindications that would warrant bypassing preferred agents; updated Appendix B therapeutic alternatives and section V dosing tables; RT4: updated	07.12.21	08.21

Reviews, Revisions, and Approvals	Date	P&T Approval Date
criteria for Mavyret pediatric age expansion to 3 years and older along with pediatric dosing and new oral pellet dosage formulation; references reviewed and updated.		
3Q 2022 annual review: no significant changes; clarified confirmed genotype criterion 2 by removing "in combination with sofosbuvir" from Vosevi-experienced members to align with preceding bullets which include genotype and previous treatment experience (approved regimens are listed in section V); added unacceptable rationale for not using preferred Epclusa within criteria (also found within Appendix E); references reviewed and updated.	05.05.22	08.22
Added specific treatment-naïve genotype 3 scenarios in Appendix B per AASLD guideline; updated Appendix E with addition of concurrent amiodarone as medical justification for inability to use Epclusa. Template changes applied to other diagnoses/indications and continued therapy section.	08.30.22	
3Q 2023 annual review: added a bypass for HCV genotype documentation if member is treatment-naïve and has either compensated cirrhosis or no cirrhosis (i.e., eligible for AASLD-IDSA simplified treatment regimen); added previous Mavyret experience to initial approval criteria scenarios per AASLD recommended regimens; eliminated adherence program participation criterion since member is already being managed by an HCV-trained specialist and due to competitor analysis; corrected continued therapy other diagnoses section template verbiage to remove redirections; references reviewed and updated.	04.17.23	08.23
3Q 2024 annual review: removed qualifier of "chronic" from HCV criteria as AASLD-IDSA recommends treatment of both acute and chronic HCV; added Appendix G for guidance on incomplete adherence and AASLD-IDSA recommended management of treatment interruptions; references reviewed and updated.	05.30.24	08.24

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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