PRIOR AUTHORIZATION POLICY

POLICY: Hepatitis C – Epclusa Prior Authorization Policy
- Epclusa® (sofosbuvir/velpatasvir tablets and oral pellets – Gilead)
- sofosbuvir/velpatasvir tablets (authorized generic to Epclusa – Gilead)

REVIEW DATE: 04/03/2024

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

The fixed-dose combination of sofosbuvir, a hepatitis C virus (HCV) nucleotide analog NS5B polymerase inhibitor, and velpatasvir, an HCV NS5A inhibitor, is indicated for the treatment of **chronic HCV genotype 1 through 6** infection in patients ≥ 3 years of age.[1] In patients with decompensated cirrhosis (Child-Pugh B or C), sofosbuvir/velpatasvir is administered with weight-based ribavirin. The FDA-approved duration of therapy with sofosbuvir/velpatasvir is 12 weeks for all patients.

Guidelines

The American Association for the Study of Liver Diseases/Infectious Diseases Society of America (AASLD/IDSA) provide recommendations for testing, monitoring, and treating HCV (December 19, 2023).[2] Instances in which the guidelines provide recommendations for sofosbuvir/velpatasvir outside of the FDA-approved indications are outlined below.

With the availability of pangenotypic HCV treatment regimens, HCV genotyping is no longer required prior to treatment initiation for all individuals. Pretreatment genotyping is still recommended in patients with cirrhosis and/or past unsuccessful

HCV treatment, because treatment regimens may differ by genotype. However, for treatment-naïve patients without cirrhosis, although genotyping may impact the preferred treatment approach, it is not required if a pangenotypic regimen is used. The recommendations provide a simplified treatment algorithm for treatment-naïve adults where genotyping is not required.[2] Treatment-naïve adults without cirrhosis are eligible for simplified treatment if they do not have hepatitis B virus (not hepatitis B serum antigen [HBsAg] positive), are not pregnant, do not have hepatocellular carcinoma, and have not had a liver transplantation. In treatment-naïve adults without cirrhosis, the recommended regimens are Mavyret® (glecaprevir/pibrentasvir tablets) for 8 weeks or sofosbuvir/velpatasvir for 12 weeks. Treatment-naïve adults with compensated cirrhosis are also eligible for simplified treatment; however, recommendations are genotype specific. In patients with compensated cirrhosis, the recommended regimen in patients with genotype 1 through 6 is Mavyret for 8 weeks; sofosbuvir/velpatasvir for 12 weeks is recommended in patients with genotype 1, 2, 4, 5, or 6 (patients with genotype 3 require baseline NS5A resistance-associated substitution testing. Those without Y93H can be treated with sofosbuvir/velpatasvir for 12 weeks).

In patients with decompensated cirrhosis, the guidelines offer a recommendation for patients who are ribavirin-ineligible to treat with sofosbuvir/velpatasvir for 24 weeks.[2] (Note: sofosbuvir/velpatasvir is FDA-approved in this setting in combination with ribavirin for 12 weeks for adult and pediatric patients). In pediatric patients with any genotype, sofosbuvir/velpatasvir with weight-based ribavirin is recommended in patients with prior exposure to an interferon-based regimen (± ribavirin) and/or sofosbuvir but no exposure to NS3/4A or NS5A protease inhibitors, with decompensated cirrhosis.

Although Vosevi® (sofosbuvir/velpatasvir/voxilaprevir tablets) is recommended in most instances for adults with no cirrhosis or compensated cirrhosis who have failed treatment with a sofosbuvir-containing regimen, sofosbuvir/velpatasvir is recommended in adults (genotypes 1 through 6) with decompensated cirrhosis who have failed therapy with a sofosbuvir-containing regimen. In this setting, sofosbuvir/velpatasvir is recommended for 24 weeks in combination with ribavirin. Data are limited to one Phase II study where sofosbuvir/velpatasvir was studied in patients with genotype 1, 2, and 3 who did not respond to velpatasvir-containing regimens including sofosbuvir/velpatasvir and Vosevi.[2,6] Retreatment with sofosbuvir/velpatasvir + ribavirin for 24 weeks yielded high overall response rates (sustained virologic response 12 weeks post-treatment [SVR12] 91% [n = 63/69]). Among patients with genotype 1 chronic HCV, 97% of patients (n = 36/37) achieved SVR12. In patients with genotype 2 chronic HCV, SVR12 was attained in 95% of patients (n = 13/14) and in patients with genotype 3 chronic HCV, SVR12 was attained in 78% of patients (n = 14/18). Baseline NS5A resistance associated substitutions did not appear to impact SVR rates. No breakdown of the proportion of patients with decompensated cirrhosis was provided in the study.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of sofosbuvir/velpatasvir. All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of patients treated with sofosbuvir/velpatasvir as well as the monitoring required for adverse events and efficacy, approval requires sofosbuvir/velpatasvir to be prescribed by or in consultation with a with a physician who specializes in the condition being treated.

- **Epclusa® (sofosbuvir/velpatasvir tablets and oral pellets – Gilead) sofosbuvir/velpatasvir tablets (authorized generic to Epclusa – Gilead) is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):**

FDA-Approved Indications

1. **Chronic Hepatitis C Virus (HCV) Genotype 1, 2, 3, 4, 5, or 6, No Cirrhosis or Compensated Cirrhosis (Child-Pugh A).** Approve for 12 weeks if the patient meets ALL of the following (A, B, C, and D):
   - **A)** Patient is ≥ 3 years of age; AND
   - **B)** Patient meets ONE of the following (i or ii):
     - **i.** Patient does not have cirrhosis; OR
     - **ii.** Patient has compensated cirrhosis (Child-Pugh A); AND
   - **C)** Patient has not been previously treated with sofosbuvir/velpatasvir; AND
   - **D)** The medication is prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician.

2. **Chronic Hepatitis C Virus (HCV) Genotype 1, 2, 3, 4, 5, or 6, Decompensated Cirrhosis (Child-Pugh B or C), Adult.** Approve for the duration below if the patient meets ALL of the following (A, B, C, and D):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient has decompensated cirrhosis (Child-Pugh B or C); AND
   - **C)** Patient meets ONE of the following (i or ii):
     - **i.** Patient is ribavirin-eligible, according to the prescriber: Approve for 12 weeks, if the medication is prescribed in combination with ribavirin; OR
     - **ii.** Patient is ribavirin-ineligible, according to the prescriber: Approve for 24 weeks; AND
   - **D)** The medication is prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician.

3. **Chronic Hepatitis C Virus (HCV) Genotype 1, 2, 3, 4, 5, or 6, Decompensated Cirrhosis (Child-Pugh B or C), Pediatric Patient.** Approve for 12 weeks if the patient meets ALL of the following (A, B, C, and D):
   - **A)** Patient is ≥ 3 years of age and < 18 years of age; AND
   - **B)** Patient has decompensated cirrhosis (Child-Pugh B or C); AND
   - **C)** The medication will be prescribed in combination with ribavirin; AND
   - **D)** The medication is prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician.

Other Uses with Supportive Evidence

4. **Chronic Hepatitis C Virus (HCV), Genotype Unknown/Undetermined.** Approve for 12 weeks if the patient meets ALL of the following (A, B, C, D, E, F, G, and H):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient does not have cirrhosis; AND
   - **C)** Patient has not previously been treated for hepatitis C virus; AND
   - **D)** Patient does not have hepatitis B virus; AND
   - **E)** Patient is not pregnant; AND
   - **F)** Patient does not have hepatocellular carcinoma; AND
   - **G)** Patient has not had a liver transplantation; AND
   - **H)** The medication will be prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician.

5. **Chronic Hepatitis C Virus (HCV), Genotype 1, 2, 3, 4, 5, or 6, Decompensated Cirrhosis (Child-Pugh B or C), Prior Null Responder, Prior Partial Responder, and Prior Relapser to sofosbuvir/velpatasvir or Vosevi**. Approve for 24 weeks if the patient meets ALL of the following (A, B, C, D, and E):
   - **A)** Patient is ≥ 3 years of age; AND
   - **B)** Patient has decompensated cirrhosis (Child-Pugh B or C); AND
   - **C)** Patient meets ONE of the following (i or ii):
     - **i.** Patient has been previously treated with sofosbuvir/velpatasvir; OR
     - **ii.** Patient has previously been treated with Vosevi; AND
   - **D)** The medication will be prescribed in combination with ribavirin; AND
   - **E)** The medication is prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician.

6. **Patient Has Been Started on sofosbuvir/velpatasvir.** Approve for an indication or condition addressed as an approval in the Recommended Authorization Criteria section (FDA-Approved Indications or Other Uses with Supportive Evidence). Approve the duration described above to complete a course therapy (e.g., a patient who should receive 12 weeks, and has received 3 weeks, should be approved for 9 weeks to complete their 12-week course).

CONDITIONS NOT COVERED

- **Epclusa® (sofosbuvir/velpatasvir tablets and oral pellets – Gilead) sofosbuvir/velpatasvir tablets (authorized generic to Epclusa – Gilead) is(are) considered experimental, investigational or unproven for ANY other use(s) including the following (this list may not be all inclusive; criteria will be updated as new published data are available):**

1. **Hepatitis C Virus (HCV) [any genotype], Combination with Any Other Direct-Acting Antivirals (DAAs) [Not Including Ribavirin].** Sofosbuvir/velpatasvir provides a complete antiviral regimen. Sofosbuvir/velpatasvir is not recommended to be used with other products containing sofosbuvir.

2. **Pediatric Patient (< 3 Years of Age).** The safety and efficacy of sofosbuvir/velpatasvir have not been established in pediatric patients < 3 years of age.[1]

REFERENCES

1. Epclusa® tablets and oral pellets [prescribing information]. Foster City, CA: Gilead; April 2022.
2. American Association for the Study of Liver Diseases and the Infectious Diseases Society of America. Testing, managing, and treating hepatitis C. Available at: http://www.hcvguidelines.org. Updated December 19, 2023. Accessed on March 26, 2024.
3. Gane EJ, Shiffman ML, Etzkorn K, et al. Sofosbuvir-velpatasvir with ribavirin for 24 weeks in HCV patients previously treated with a direct-acting antiviral regimen. *Hepatology*. 2017;66(4):1083-1089.

HISTORY

Type of Revision	Summary of Changes	Review Date
Early Annual Revision	**Chronic Hepatitis C Virus (HCV), Genotype Unknown/Undetermined:** A new condition of coverage was added to "Other Uses with Supportive Evidence". Patients meeting these criteria are approved for 12 weeks of sofosbuvir/velpatasvir.	04/05/2023
Selected Revision	**Conditions Not Covered : Life Expectancy Less Than 12 Months Due to Non-Liver Related Comorbidities**. This condition was removed.	02/28/2024
Annual Revision	No criteria changes.	04/03/2024