# Clinical Policy: Ledipasvir/Sofosbuvir (Harvoni)

Reference Number: IL.PHAR.279
Effective Date: 09.16
Last Review Date: 6.22.22
Line of Business: Medicaid

Revision Log

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

## Description

Ledipasvir/sofosbuvir (Harvoni®) is a fixed-dose combination of ledipasvir, a hepatitis C virus (HCV) NS5A inhibitor, and sofosbuvir, an HCV nucleotide analog NS5B polymerase inhibitor.

## FDA Approved Indication(s)

Harvoni is indicated for the treatment of adults and pediatric patients 3 years of age and older with chronic HCV:

- Genotype 1, 4, 5, or 6 infection without cirrhosis or with compensated cirrhosis
- Genotype 1 infection with decompensated cirrhosis, in combination with ribavirin
- Genotype 1 or 4 infection who are liver transplant recipients without cirrhosis or with compensated cirrhosis, in combination with 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 Harvoni is **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria**

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

1. The patient is 3 years of age or over, and has a diagnosis of Chronic Hepatitis C infection genotype 1, 4, 5 or 6 confirmed by lab documentation and quantitative baseline HCV-RNA.
2. Patient's Metavir/fibrosis score must be documented in the request for prior approval. The patient's Metavir/fibrosis score can be determined based on Liver Biopsy, Transient Elastography (FibroScan ®), FibroTest®/FibroSure®, or FibroMeter™.
3. Prescriber must provide a copy of the following lab test reports, completed within 3 months prior to the request for prior approval, unless otherwise noted:
    a. Baseline quantitative HCV RNA level (within 1 year of request for prior approval)
    b. ALT and AST
    c. CBC
    d. GFR
    e. INR, albumin, and bilirubin, for stage 4 fibrosis only
4. Negative HBV screen; or evidence of immunity due to vaccination or previous natural infection, and if member is acutely or chronically infected, must provide quantitative HBV

DNA and verification of treatment regimen (Interpretation of Hepatitis B Serologic Test Results: https://www.cdc.gov/hepatitis/hbv/pdfs/serologicchartv8.pdf)

5. Prescriber must provide clinic or consultation notes from specialist consultation (see #9).
6. In the opinion of the prescriber, the patient is able to make appropriate decisions about treatment and comply with dosing and other instructions, and is capable of completing therapy as prescribed. The prescriber must provide a copy of a signed patient commitment letter for all hepatitis C treatment regimens.
7. The treatment regimen prescribed is not for an indication outside of the FDA approved labeling, and no contraindications or significant drug interactions to treatment exist as specified in the product labeling.
8. Prescribing provider is responsible for addressing ongoing misuse of alcohol and/or continued use of illicit IV drugs (if appropriate).
9. The patient has no history of an incomplete course of treatment with DAAs. (Prior treatment with telaprevir, boceprevir, and DAA regimens used in combination with interferons is not taken into consideration for purposes of this criterion.) HFS will review requests and pertinent clinical information for an additional course of DAA, after previous such therapy, on a case-by-case basis, considering whether the person has received counseling for or otherwise addressed the cause of non-adherence, where applicable.
10. The prescriber can be any practitioner licensed to prescribe, or licensed to prescribe in collaboration with a physician who holds a current unrestricted license to practice medicine. If the prescriber is NOT a gastroenterologist, hepatologist, transplant hepatologist, or infectious disease specialist, the prescriber must engage in a one-time consultation with one of these specialists within the 3 months prior to the request for prior authorization. This one-time consultation may be via telephone, video-conference, or telehealth technology. The records containing a specialist recommendation for treatment with a DAA regimen must be submitted with the request for prior approval.
11. Non-adherence with the regimen (> 7 days) or patient's failure to obtain refills in a timely manner may result in discontinuation of current prior approval. Non-adherence or failure to obtain refills that result from situations that are beyond the patient's control will not result in discontinuation of a prior approval.
12. The prescriber agrees to submit HCV RNA levels to HFS for patients prescribed DAAs within 8 weeks after beginning treatment, 12 weeks post treatment, and 24 weeks post treatment. If at any point the patient's viral load is undetectable, the prescriber is not required to submit any subsequent test. Prescriber's failure to submit a lab report in a timely fashion due to patient's non-cooperation may result in denial of retreatment, should that situation arise. However, situations beyond the control of the prescriber or the patient will not result in a denial of re-treatment under this criteria.
13. Requests for exceptions to these criteria can be made when the services are medically necessary to meet the medical needs of the patient. Requests for exceptions to these criteria can be made on the prior approval form itself and will be reviewed on a case-by-case basis.
14. One of the following (a, b, or c):
    a. Member must use Mavyret® or sofosbuvir/velpatasvir (Epclusa®) (*generic preferred*), unless clinically significant adverse effects are experienced or both are contraindicated (*see Appendix E)*;

b. If member has clinically significant adverse effects or contraindications to both Mavyret and sofosbuvir/velpatasvir (Epclusa) (*generic preferred*), member must use generic version of Harvoni (*see Appendix E*);
c. Member has clinically significant adverse effects or contraindications to Mavyret, sofosbuvir/velpatasvir (Epclusa) (*generic preferred*), **and** generic version of Harvoni (*clinical documentation required*).

15. Dose does not exceed ledipasvir/sofosbuvir 90 mg/400 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; a 2 week buffer should be added to the authorization in case the medication is not filled immediately)*

**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.PMN.255 for Medicaid; 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.PMN.16 for Medicaid; 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.PMN.53 for Medicaid.

## II. 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.

## III. 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.*

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| sofosbuvir/ velpatasvir (Epclusa®) | **Genotype 1 through 6:**<br>Without cirrhosis or with compensated cirrhosis, treatment-naïve or treatment-experienced* patient<br><br>One tablet PO QD for 12 weeks | Adult/Peds ≥ 30 kg: sofosbuvir 400 mg /velpatasvir 100 mg (one tablet) per day;<br><br>Peds 17 to < 30 kg: sofosbuvir 200 mg /velpatasvir 50 mg per day;<br><br>Peds < 17 kg: sofosbuvir 150 mg /velpatasvir 37.5 mg per day |
| sofosbuvir/ velpatasvir (Epclusa®) | **Genotype 1 through 6:**<br>With decompensated cirrhosis treatment-naïve or treatment-experienced* patient<br><br>One tablet PO QD with weight-based RBV for 12 weeks<br><br>(GT 1, 4, 5, or 6 with decompensated cirrhosis and RBV-ineligible may use: one tablet PO QD for 24 weeks)‡ | |
| sofosbuvir/ velpatasvir (Epclusa®) | **Genotype 1 through 6:**<br>Treatment-naïve and treatment-experienced patients, post-liver transplant with compensated cirrhosis or without cirrhosis<br><br>One tablet PO QD for 12 weeks | |
| sofosbuvir/ velpatasvir (Epclusa®) | **Genotype 1 through 6:**<br>With decompensated cirrhosis in whom prior sofosbuvir- or NS5A-based treatment experienced failed<br><br>One tablet PO QD with weight-based RBV for 24 weeks‡ | One tablet (sofosbuvir 400 mg /velpatasvir 100 mg) per day |
| sofosbuvir/ velpatasvir (Epclusa®) | **Genotype 1 through 6:**<br>Treatment-naïve and treatment-experienced patients, post-liver transplant with decompensated cirrhosis<br><br>One tablet PO QD with RBV (starting at 600 mg and increased as tolerated) for 12 weeks (treatment naïve) or 24 weeks (treatment experienced)‡ | One tablet (sofosbuvir 400 mg /velpatasvir 100 mg) per day |
| Mavyret® (glecaprevir /pibrentasvir) | **Genotypes 1 through 6:**<br>Treatment-naïve<br><br>Without cirrhosis or with compensated cirrhosis:<br>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; |

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| Mavyret® (glecaprevir /pibrentasvir) | **Genotypes 1, 4, 5, or 6:**<br>Treatment-experienced with IFN/pegIFN + RBV +/- sofosbuvir<br><br>Without cirrhosis:<br>Three tablets PO QD for 8 weeks<br><br>With compensated cirrhosis:<br>Three tablets PO QD for 12 weeks | Peds age 3 years to < 12 years of age with body weight < 20 kg: glecaprevir 150 mg/pibrentasvir 60 mg per day;<br><br>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;<br><br>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 |
| Mavyret® (glecaprevir /pibrentasvir) | **Genotype 1:**<br>Treatment-experienced with NS5A inhibitor without prior NS3/4A protease inhibitor<br><br>Without cirrhosis or with compensated cirrhosis:<br>Three tablets PO QD for 16 weeks | |
| Mavyret® (glecaprevir /pibrentasvir) | **Genotype 1:**<br>Treatment-experienced with NS3/4A protease inhibitor without prior NS5A inhibitor<br><br>Without cirrhosis or with compensated cirrhosis:<br>Three tablets PO QD for 12 weeks | |
| Mavyret® (glecaprevir /pibrentasvir) | **Genotypes 1 through 6:**<br>Treatment-naïve or treatment-experienced, post-liver or kidney transplantation without cirrhosis or with compensated cirrhosis<br><br>Three tablets PO QD for 12 weeks | |

*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.*
ǂ *Off-label, AASLD-IDSA guideline-supported dosing regimen*

*Appendix C: Contraindications/Boxed Warnings*

- If used in combination with RBV, all contraindications to RBV also apply to Harvoni combination therapy.
- Boxed warning(s): risk of hepatitis B virus 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 Mavyret (preferred product):
  - Moderate or severe hepatic impairment (Child-Pugh B or C) or those with any history of prior hepatic decompensation: use of Mavyret is not recommended as postmarketing cases of hepatic decompensation/failure have been reported in these patients.
  - Drug-drug interactions with the following agents:
    - Atazanavir
    - Efavirenz
- Acceptable medical justification for inability to use Epclusa (preferred product):
  - In patients indicated for co-administration of Epclusa with ribavirin: contraindications to ribavirin
- 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.
- Treatment with Harvoni for 8 weeks can be considered in treatment-naïve patients without cirrhosis who have pre-treatment HCV RNA less than 6 million IU/mL. In the ION-3 trial, patients 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<br>Less than 34 umol/L | 2-3 mg/dL<br>34-50 umol/L | Over 3 mg/dL<br>Over 50 umol/L |

| | 1 Point | 2 Points | 3 Points |
|---|---|---|---|
| Albumin | Over 3.5 g/dL<br>Over 35 g/L | 2.8-3.5 g/dL<br>28-35 g/L | Less than 2.8 g/dL<br>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<br>Grade I-II | Moderate-severe / poorly controlled.<br>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

*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

## IV. Dosage and Administration

| Indication: Patients age ≥ 3 years with chronic HCV infection | | | |
|---|---|---|---|
| **Indication** | **Dosing Regimen** | **Maximum Dose** | **Reference** |
| Genotype 1 chronic HCV infection: | One tablet PO QD for:<br><br>Treatment-naïve without cirrhosis, who are HIV-uninfected, AND whose HCV viral load is < 6 million IU/mL: for 8 weeks‡<br><br>Treatment-naïve without cirrhosis (not meeting the 8 week treatment indication requirements above) or with compensated cirrhosis: for 12 weeks<br><br>Treatment-experienced* without cirrhosis: for 12 weeks<br><br>Treatment-experienced* with compensated cirrhosis: Harvoni plus weight-based RBV for 12 weeks (or Harvoni for 24 weeks if RBV-intolerant) | *Weight ≥ 35 kg*: One tablet (sofosbuvir 400 mg / ledipasvir 90 mg) per day<br><br>*Weight ≥ 17 to < 35 kg*:<br>One tablet (sofosbuvir 200 mg / ledipasvir 45 mg) per day<br><br>*Weight < 17 kg*:<br>One packet of pellets (sofosbuvir 150 mg / ledipasvir 33.75 mg) per day | 1) FDA-approved labeling<br>2) AASLD-IDSA (updated March 2021) |
| Genotype 1, 4‡, 5‡, or 6‡ with decompensated cirrhosis | One tablet PO QD plus low initial dose of RBV (600 mg, increased as tolerated) for 12 weeks | | 1) FDA-approved labeling<br>2) AASLD-IDSA (updated March 2021) |
| Genotype 1, 4, 5, or 6 with decompensated cirrhosis:<br>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‡ | | AASLD-IDSA (updated March 2021) |
| Genotype 1, 4, 5‡, or 6‡ post-liver transplantation:<br>Treatment-naive and treatment-experienced* patients without cirrhosis, with compensated | Without cirrhosis or with compensated cirrhosis: One tablet PO QD plus RBV for 12 weeks<br><br>AASLD recommends patients without cirrhosis or with compensated cirrhosis | | 1) FDA-approved labeling<br>2) AASLD-IDSA (updated March 2021) |

| Indication: Patients age ≥ 3 years with chronic HCV infection | | | |
|---|---|---|---|
| **Indication** | **Dosing Regimen** | **Maximum Dose** | **Reference** |
| cirrhosis, or with decompensated cirrhosis | receive one tablet PO QD for 12 weeks (without ribavirin)ǂ<br><br>With decompensated cirrhosis: One tablet PO QD with RBV for 12 weeks (treatment-naïve) or 24 weeks (treatment-experienced*)ǂ | | |
| Genotype 4, 5, or 6: Treatment-naïve and treatment-experienced* patients without cirrhosis or with compensated cirrhosis | One tablet PO QD for 12 weeks | | FDA-approved labeling |

*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*

## V. Product Availability

Tablets: 90 mg of ledipasvir and 400 mg of sofosbuvir; 45 mg of ledipasvir and 200 mg of sofosbuvir

Oral pellets: 45 mg of ledipasvir and 200 mg of sofosbuvir; 33.75 mg of ledipasvir and 150 mg of sofosbuvir

## VI. References

1. Illinois Department of Healthcare and Family Services: Criteria for Prior Aproval of Direct-Acting Antivirals (DAAs) for Hepatitis C. Available at: https://www2.illinois.gov/hfs/SiteCollectionDocuments/HFSHepCDAACriteriaWordFINAL11012018.pdf. Accessed April 20, 2022.
2. Harvoni Prescribing Information. Foster City, CA: Gilead Sciences, Inc.; March 2020. Available at http://www.harvoni.com. Accessed May 5, 2022.
3. 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 September 29, 2021. Available at: https://www.hcvguidelines.org/. Accessed May 5, 2022.
4. CDC. Hepatitis C Q&As for health professionals. Last updated August 7, 2020. Available at:
1) https://www.cdc.gov/hepatitis/hcv/hcvfaq.htm. Accessed May 5, 2022. .

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|---|---|---|
| New policy created, split from CP.PHAR.17 Hepatitis C Therapies policy.<br>HCV RNA levels over six-month period added to confirm infection is chronic. Life expectancy "≥12 months if HCC and awaiting transplant" is modified to indicate "≥12 months with HCV therapy." Testing criteria reorganized by "no cirrhosis"/"cirrhosis" consistent with the regimen tables; HCC population is included under "cirrhosis" and broadened to incorporate HCC amenable to curative measures (resection, ablation, transplant).<br>Methods to diagnose fibrosis/cirrhosis are modified to require presence of HCC, liver biopsy or a combination of one serologic and one radiologic test. Serologic and radiologic tests are updated and correlated with METAVIR per Appendix B. Removed creatinine clearance restriction – not a contraindication. Criteria added excluding post-liver transplantation unless regimens specifically designate. Dosing regimens are presented in Appendix D and E per AASLD guidelines and FDA-approved indications.<br>The initial approval period is shortened to 8 weeks. | 08.16 | 09.16 |
| Added pediatric (≥12 years or ≥35 kg) indication expansion for GT 1,4,5,6. Deleted positive response to therapy requirement per specialist feedback. | 04.17 | 05.18 |
| Policy converted to new template. Added requirement for prevention of HBV reactivation. Consolidated appendix D and E into dosing and administration in section V; extended initial approval duration up to full regimen; deleted adherence requirement in continued therapy; added maximum dose requirement, added documentation of positive response to therapy and continuity of care, and removed CIs in section II, added reference column in section V. Added preferencing information requiring Mavyret for FDA-approved indications.<br>Safety criteria was applied according to the safety guidance discussed at CPAC and endorsed by Centene Medical Affairs. Exception made to require Hep B screening for all patients prior to treatment. | 08.17 | 09.17 |
| 3Q 2018 annual review: removed requirement for HBV verification; added baseline viral load requirement for treatment-naïve adult with GT 1 for determination of treatment duration; added requirement for documentation of previous treatment and cirrhosis status; expanded duration of tx required for COC from 30 days to 60 days; required verification of genotype for COC; removed conditional requirement for RBV CI; references reviewed and updated. | 05.22.18 | 08.18 |

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|---|---|---|
| Removed requirement for advanced fibrosis or other candidacy for therapy following approved clinical guidance and removed sobriety requirement. | 2.26.19 | 4.19 |
| 2Q2021 Annual Review: **Updated** FDA Approved Indication**; Added** Authorized generic version of Harvoni is prescribed, unless medical justification supports inability to use the authorized generic; **Added** require AG Epclusa for age 6 to 11 years, or weight 17 kg to 44 kg; revised to require Mavyret or AG Epclusa for age 12 years or older, or weight at least 45 kg; **Added** new prescriber requirement to include a "provider who has expertise in treating HCV based on a certified training program"; **Added** Appendix G (Healthcare Provider HCV Training); Dosage and Administration tables updated; **removed** medical justification for ability to use Mavyret from Appendix F; **Added** Child-Pugh Score in Appendix E and Appendix F (Healthcare Provider HCV Training) added; **removed** documented sobriety from alcohol and illicit IV drugs for ≥ 6 months prior to starting therapy; **Removed** *Appendix D: Approximate Scoring Equivalencies using METAVIR F3/F4;* ; **Updated** table Dosing and Administration; references reviewed and updated | 6.17.21 | |
| : updated criteria for age requirement of Epclusa & Mavyret use due to their pediatric age expansions; revised medical justification language for not using authorized generic version of Harvoni to "must use" language; included reference to Appendix F with addition of contraindications that would warrant bypassing preferred agents; updated Appendix B therapeutic alternatives and section V dosing tables; references reviewed and updated. | 9.14.21 | |
| 1Q2021 Annual Review: Reorganized criteria to clarify intent in steerage. | 2.21.2022 | |
| 3Q 2022 annual review: no significant changes; references reviewed and updated. | 6.22.22 | |
| 3Q2023 Annual Review: updated policy to align with HFS criteria and MDN.CP.PHAR.279; references reviewed and updated. | 8.8.23 | |

**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.