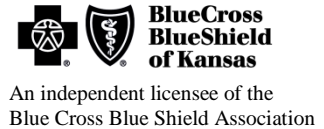


Medical Policy



Title: Hepatitis B / Hepatitis C Peg-interferon

- See also:*
- *Hepatitis C First Generation – Through Preferred Agent(s)*
 - *Hepatitis C Second Generation – Through Preferred Agent(s)*

➤ **Prime Therapeutics will review Prior Authorization requests.**

Prior Authorization Forms:

<https://www.bcbsks.com/CustomerService/Forms/pdf/PriorAuth-6033KS-PEGI.pdf>

Link to Drug List (Formulary):

<https://www.bcbsks.com/drugs/>

Professional

Original Effective Date: January 1, 2012
 Revision Date(s): March 28, 2012;
 July 1, 2012, January 1, 2013;
 January 1, 2014; February 10, 2014;
 April 22, 2014; June 15, 2014;
 October 28, 2014; February 24, 2015;
 September 1, 2015, January 1, 2016;
 June 1, 2016; September 1, 2016;
 December 1, 2017
 Current Effective Date: December 1, 2017

Institutional

Original Effective Date: January 1, 2012
 Revision Date(s): March 28, 2012;
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 December 1, 2017
 Current Effective Date: December 1, 2017

State and Federal mandates and health plan member contract language, including specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. To verify a member's benefits, contact [Blue Cross and Blue Shield of Kansas Customer Service](#).

The BCBSKS Medical Policies contained herein are for informational purposes and apply only to members who have health insurance through BCBSKS or who are covered by a self-insured group plan administered by BCBSKS. Medical Policy for FEP members is subject to FEP medical policy which may differ from BCBSKS Medical Policy.

The medical policies do not constitute medical advice or medical care. Treating health care providers are independent contractors and are neither employees nor agents of Blue Cross and Blue Shield of Kansas and are solely responsible for diagnosis, treatment and medical advice.

If your patient is covered under a different Blue Cross and Blue Shield plan, please refer to the Medical Policies of that plan.

DESCRIPTION

The intent of the Peginterferon Prior Authorization (PA) program is to appropriately select patients for therapy according to the Food and Drug Administration (FDA) approved product labeling and/or clinical guidelines and/or clinical studies. The PA process will evaluate the use of these agents when there is supporting clinical evidence for their use.

Target Drugs

- **Pegasys**[®] (peginterferon alfa-2a)
- **PegIntron**[®] (peginterferon alfa-2b)

FDA Approved Indications and Dosage^{1,2}

Agents*	Indications	Dose and Interval [‡]
Pegasys (peginterferon alfa-2a)	Hepatitis C, in combination with other hepatitis C virus (HCV) antiviral drugs in patients 5 years of age and older with compensated liver disease	<ul style="list-style-type: none"> • Genotype 1-4: 180 mcg subcutaneous once weekly • Genotype 5, 6: There is insufficient data for dosage recommendations
	Hepatitis C, as monotherapy, only in patients with contraindication or significant intolerance to other HCV antiviral drugs	
	HBeAg positive and HBeAG negative Hepatitis B in adult patients with compensated liver disease and evidence of viral replication and liver inflammation	<ul style="list-style-type: none"> • 180 mcg subcutaneous once weekly
PegIntron (peginterferon alfa-2b)	Chronic Hepatitis C with compensated liver disease	<ul style="list-style-type: none"> • Adult dose: 1.5 mcg/kg/week • Pediatric dose: 60 mcg/m²/week

* For peg-interferons for oncology (e.g. Sylatron) and Multiple sclerosis (e.g. Plegridy), refer to the SA Oncology PA/QL and Multiple Sclerosis PA/QL programs respectively.

‡ Duration of treatment is dependent upon the genotype and the regimen in which the peg-interferon is used

POLICY**Prior Authorization Criteria for Approval**

- A. **Pegasys or PegIntron** will be approved when ALL of the following are met:
1. The patient does not have any FDA labeled contraindications to the requested agent
- AND**

2. ONE of the following:
 - a. The patient has a diagnosis of chronic hepatitis B and BOTH of the following:
 - i. The chronic hepatitis B infection has been confirmed by serological markers
AND
 - ii. The patient has not been administered peg-interferon for more than 18 months for treatment of chronic hepatitis B
 - OR**
 - b. BOTH of the following:
 - i. The patient has a diagnosis of chronic hepatitis C genotype 1, 2, 3, or 4
AND
 - ii. The requested agent will be used in a treatment regimen AND length of therapy recommended for the patient's genotype as noted in Table 1, 2, 3, and 4 (FDA labeling)

Length of Approval:

- **Hepatitis B:** Up to 18 months
- **Hepatitis C:** Up to the duration as determined in Table 1, 2, 3, and 4

Table 1: Olysio, Peg-interferon (PEG-IFN), and Ribavirin Treatment Recommendations based on FDA labeling

Genotype	Patient population	Treatment regimen	Duration of therapy
1 or 4	Treatment naive and prior relapsers* HCV monoinfected patients without cirrhosis or with compensated cirrhosis (Child-Pugh A)	Olysio + PEG-IFN + RBV	Olysio: 12 weeks PEG-IFN: 24 weeks
	Treatment naive and prior relapsers* with HCV/HIV co-infected patients without cirrhosis	Olysio + PEG-IFN + RBV	Olysio: 12 weeks PEG-IFN: 24 weeks
	Treatment naive and prior relapsers* with HCV/HIV co-infection with compensated cirrhosis (Child-Pugh A)	Olysio + PEG-IFN + RBV	Olysio: 12 weeks PEG-IFN: 48 weeks
	Prior non-responders (including partial [±] and null responders [^]) without cirrhosis or with compensated cirrhosis (Child-Pugh A) and with or without HIV co-infection	Olysio + PEG-IFN + RBV	Olysio: 12 weeks PEG-IFN: 48 weeks

*Prior relapse: HCV RNA not detected at the end of prior IFN based therapy and HCV RNA detected during follow up.

[±] Prior partial responder: Prior on-treatment $\geq 2 \log_{10}$ IU/mL reduction in HCV RNA from baseline at week 12 and HCV RNA detected at the end of prior IFN based therapy.

[^] Prior null responder: Prior on treatment $< 2 \log_{10}$ reduction in HCV RNA from baseline at week 12 during prior IFN based therapy.

Table 2: Sovaldi + PEG-IFN + RBV Treatment Recommendations based on FDA approved labeling

Genotype*	FDA approved regimen	Duration of therapy
1a or 1b	Sofosbuvir + PEG-IFN + RBV	12 weeks
4	Sofosbuvir + PEG-IFN + RBV	12 weeks

*Includes patients with HCV/HIV co-infection

Table 3: Pegasys + RBV Treatment Recommendations based on FDA labeling

Genotype	FDA approved regimen	Duration of therapy
1 or 4	Pegasys + RBV	48 weeks
2 or 3	Pegasys + RBV	24 weeks
5 or 6	There is insufficient data for dosage and duration	

Table 4: PegIntron + RBV Treatment Recommendations based on FDA labeling

Genotype	FDA approved regimen	Duration of therapy
1	PegIntron + RBV	48 weeks
2 or 3	PegIntron + RBV	24 weeks

Agent(s)	Contraindication(s)
Pegasys (peginterferon alfa-2a)	<ul style="list-style-type: none"> ▪ Known hypersensitivity reactions such as urticaria, angioedema, bronchoconstriction, anaphylaxis, or Stevens-Johnson syndrome to alpha interferons, including Pegasys, or any of its components. ▪ Autoimmune hepatitis. ▪ Hepatic decompensation (Child-Pugh score greater than 6 [class B and C]) in cirrhotic patients before treatment. ▪ Hepatic decompensation with Child-Pugh score greater than or equal to 6 in cirrhotic CHC patients coinfecting with HIV before treatment. ▪ In neonates and infants because it contains benzyl alcohol. ▪ When used in combination with other HCV antiviral drugs, the contraindications applicable to those agents are applicable to combination therapies. ▪ Pegasys combination treatment with ribavirin is contraindicated in women who are pregnant and men whose female partners are pregnant.
PegIntron (peginterferon alfa-2b)	<ul style="list-style-type: none"> ▪ Known hypersensitivity reactions, such as urticaria, angioedema, bronchoconstriction, anaphylaxis, Stevens-Johnson syndrome, and toxic epidermal necrolysis to interferon alpha or any other component of the product. ▪ Autoimmune hepatitis. ▪ Hepatic decompensation (Child-Pugh score greater than 6 [class B and C]) in cirrhotic CHC patients before or during treatment. ▪ PegIntron/ribavirin combination therapy is additionally contraindicated in women who are pregnant. Ribavirin may cause fetal harm when administered to a pregnant woman. Ribavirin is contraindicated in women who are or may become pregnant. If ribavirin is used during pregnancy, or if the patient becomes pregnant while taking ribavirin, the patient should be apprised of the potential hazard to her fetus. Men whose female partners are pregnant. Patients with hemoglobinopathies (e.g., thalassemia major, sickle-cell anemia). ▪ Patients with creatinine clearance less than 50 mL/min.

RATIONALE

Hepatitis B Disease Background⁵

Hepatitis B is an infection of the liver caused by the Hepatitis B virus (HBV). The prevalence of chronic HBV infection is estimated at 240 million persons globally and 704,000 persons in the United States. Deaths due to cirrhosis and cancer secondary to chronic HBV infection are estimated at 310,000 and 340,000 per year respectively. The goal of treatment of chronic HBV infection is to decrease morbidity and mortality.

Diagnosis of Hepatitis B infection should include lab tests to confirm HBV serology and HBV replication. A thorough clinical history and physical examination should also be performed. Checking for other viral infections such as hepatitis C and HIV are also recommended.

Initial Evaluation of HBaAG-Positive* Patients

	History/Physical Examination	Routine Laboratory Tests	Serology/Virology	Imaging/Staging Studies
All patients	Symptoms/signs of cirrhosis Alcohol and metabolic risk factors Family history of HCC Vaccination status	CBC including platelet count, AST, ALT, total bilirubin, alkaline phosphatase, albumin, INR	HBeAg/anti-HBe HBV DNA quantitation Anti-HAV to determine need for vaccination	Abdominal ultrasound Vibration-controlled transient elastography or serum fibrosis panel (APRI, FIB-4, or FibroTest)
Select patients		Tests to rule out other causes of chronic liver diseases if elevated liver test(s) AFP, GGT	HBV genotype Anti-HDV Anti-HCV Anti-HIV in those who have not undergone one-time screening (ages 13-64)	Liver biopsy

Abbreviation:s INR, international normalized ratio; GGT, gamma-glutamyl transpeptidase.

*HBaSG-Hepatitis B surface antigen

There are several agents currently indicated for treatment of chronic HBV. They include Peg-interferon, lamivudine, telbivudine, entecavir, tenofovir and adefovir. AASLD recommends peg-interferon, entecavir, or tenofovir as preferred initial therapy for adults with immune-active chronic HBV infection.

Peginterferon alfa-2a has an FDA approved indication for chronic hepatitis B while peginterferon alfa-2b is not FDA approved for chronic hepatitis B, however, there are studies that support its use for this indication.

Hepatitis C Disease Background^{3,4}

Hepatitis C is an infection of the liver caused by the Hepatitis C virus (HCV) and is one of the leading causes of chronic liver disease in the United States. According to the Centers for Disease Control and Prevention (CDC), there were an estimated 3.5 million people infected with hepatitis C as of 2015. Hepatitis C infection can either be acute or chronic. Acute HCV infection is defined as presenting within 6 months following exposure to the virus.¹⁸ The infection is defined as chronic if the virus is present beyond 6 months following exposure. 70% to 80% of those infected with HCV will go on to develop chronic HCV infection.

The American Association of the Study of Liver Disease (AASLD) and the Infectious Disease Society of America (IDSA) have developed guidelines to aid in the management of hepatitis C. The guidelines address issues ranging from testing and linkage to care to the optimal treatment regimen based on patient situations.

AASLD/IDSA guidelines recommend direct acting antivirals (DAAs) as the mainstay of treatment for chronic HCV infection. Certain DAAs may be used as monotherapy while others require use in combination with other agents including peg-interferon, ribavirin, and other DAAs. The AASLD/IDSA treatment guidelines recommend against treatment of chronic hepatitis C with peg-interferon based regimens as they are considered inferior to the non-peg-interferon DAA based regimens.

AASLD guidelines on when and in whom to treat: ⁴

The goal of therapy is to reduce all-cause mortality and liver-related health adverse consequences, including end-stage liver disease and hepatocellular carcinoma, by the achievement of virologic cure as evidenced by an SVR. According to the AASLD/IDSA guidelines, treatment is recommended for all patients with chronic HCV infection, except those with short life expectancies that cannot be remediated by treating HCV, by transplantation, or by other directed therapy. Treatment should be initiated early because delaying therapy may decrease the benefits of eradicating the hepatitis C viral infection.

REVISIONS	
01-01-2014	In I. Hepatitis B / Oncology Description section: <ul style="list-style-type: none"> ▪ Updated FDA Approved Indications and Dosage chart
	In I. Hepatitis B / Oncology Policy section: <ul style="list-style-type: none"> ▪ In Item A, B, and C added, "The patient does not have any FDA labeled contraindications to therapy" and revised accompanying wording accordingly.
	In II Hepatitis C Agents Header and Description section: <ul style="list-style-type: none"> ▪ Revised "II. Hepatitis C Agents – Through Preferred Peginterferon Agent" to read, "II. Hepatitis C Agents – Through Preferred Hepatitis C Agents" ▪ Updated Description
	In II Hepatitis C Agents Policy section: <ul style="list-style-type: none"> ▪ In Item I A changed "BOTH of the following are met:" to "ALL of the following are met:" ▪ In Item I A added, "The patient does not have any FDA labeled contraindications to therapy" and revised accompanying wording accordingly. ▪ In Item I B revised "(peginterferon, ribavirin, and Incivek or Victrelis) Oral plus Preferred Peginterferon alfa (Pegasys)..." to "(peginterferon, ribavirin, protease inhibitor Preferred Oral plus Preferred Peginterferon alfa (Pegasys)..." ▪ In Item I B 4 revised "The patient is NOT receiving a contraindicated medication (see table on page 10)" to read "The patient does NOT have any FDA labeled contraindications, including coadministration with contraindicated medications (see table on page 10)" ▪ In I C added "(DUAL or TRIPLE THERAPY)" to read, "Nonpreferred peginterferon (PegIntron (DUAL or TRIPLE THERAPY))" ▪ In II added "(TRIPLE THERAPY) to read "Renewal Evaluations - (TRIPLE THERAPY)" ▪ In II A 3 and II B 3 added "or undetectable" to read, "...with a viral load less than 100 IU/mL* or undetectable" ▪ In B 3 removed "with Victrelis" ▪ In II C 3 and II D 3 added "or undetectable" to read, "...with a viral load less than 100 IU/mL* or undetectable" ▪ Updated Contraindicated Medications chart
	Rationale updated
	Added Coding section and "There are no specific HCPCS codes for the drugs listed in this policy."
	References updated

REVISIONS																				
02-10-2014	<p>Title updated to add: "Olysio™ (simeprevir), Sovaldi™/sofosbuvir"</p> <ul style="list-style-type: none"> ▪ In Description section II Hepatitis C Agents – Through Preferred Hepatitis C Agents updated ▪ Description updated ▪ Target Drugs – Oral Agents chart updated ▪ FDA Approved Indications and Dosage updated ▪ Dosing updated <p>In Policy section II HEPATITIS C AGENTS - Through Preferred Hepatitis C Agents:</p> <ul style="list-style-type: none"> ▪ Added Item I B 5, "For OLYSIO, if the patient has subtype 1a, must NOT have the NS3 Q80K polymorphism AND" ▪ Revised Item I B 6 to change Incivek dosages from, "-750 mg 3 times a day (7-9 hours apart); -1125 mg 3 times a day (7-9 hours apart) if coadministration with efavirenz" to "-1125 mg 2 times a day (10-14 hours apart; -1500 mg 2 times a day (10-14 hours apart) if coadministration with efavirenz" and added, " Olysio:-150 mg once daily" ▪ Added to Item I B 8, "and Olysio" to read, "Incivek and Olysio" ▪ Added to Item I B Length of Approval, "or Olysio" to read "Incivek or Olysio" ▪ Revised Item I C Length of Approval from "Triple therapy (peginterferon + ribavirin + Incivek) = 8 weeks" and "Triple therapy (peginterferon + ribavirin + Victrelis) = 1 weeks" to "Triple therapy (peginterferon plus Incivek or Olysio) = 8 weeks" and "Triple therapy (peginterferon plus Victrelis) = 16 weeks" ▪ Added section I D "Initial Evaluation – Sovaldi (sofosbuvir)" <ol style="list-style-type: none"> 1. The patient does not have any FDA labeled contraindications AND 2. ONE of the following: <ol style="list-style-type: none"> a. The patient has a diagnosis of hepatitis C genotype 2 or 3 confirmed by serological markers AND will receive concomitant ribavirin OR b. The patient has a diagnosis of hepatitis C genotype 4 confirmed by serological markers AND will receive concomitant peginterferon alfa and ribavirin OR c. The patient has a diagnosis of hepatitis C genotype 1 confirmed by serological markers AND ONE of the following: <ol style="list-style-type: none"> 1) The patient will receive concomitant peginterferon alfa and ribavirin OR 2) The patient is ineligible to receive peginterferon alfa AND will receive concomitant ribavirin d. The patient has hepatitis C genotype 1 through 4 confirmed by serological markers and hepatocellular carcinoma AND ALL of the following: <ol style="list-style-type: none"> 1) The patient is pre-transplant AND 2) ONE of the following: <ol style="list-style-type: none"> a) The patient has a single tumor 5 cm or less in diameter OR b) The patient has up to 3 tumors with each being 3 cm or less in diameter AND 3) The patient has NO extrahepatic manifestations of cancer or evidence of vascular invasion of tumor AND 3. The patient will NOT be receiving an NS3/4 A protease inhibitor (i.e. Incivek, Olysio, or Victrelis) at the same time as Sovaldi AND 4. The dose is within the FDA labeled dose" <ul style="list-style-type: none"> ▪ Added Length of approval chart <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;">Genotype</th> <th style="width: 33%;">Combination Medication</th> <th style="width: 33%;">Length of Approval</th> </tr> </thead> <tbody> <tr> <td>1 or 4</td> <td>Pegylated interferon AND ribavirin</td> <td>12 weeks</td> </tr> <tr> <td>1</td> <td>Ribavirin ONLY</td> <td>24 weeks</td> </tr> <tr> <td>2</td> <td>Ribavirin</td> <td>12 weeks</td> </tr> <tr> <td>3</td> <td>Ribavirin</td> <td>24 weeks</td> </tr> <tr> <td>Hepatocellular Carcinoma -Pre-transplant</td> <td>Ribavirin</td> <td>48 weeks</td> </tr> </tbody> </table> 		Genotype	Combination Medication	Length of Approval	1 or 4	Pegylated interferon AND ribavirin	12 weeks	1	Ribavirin ONLY	24 weeks	2	Ribavirin	12 weeks	3	Ribavirin	24 weeks	Hepatocellular Carcinoma -Pre-transplant	Ribavirin	48 weeks
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	<ul style="list-style-type: none"> ▪ Added section I E "Initial Evaluation Nonpreferred peginterferon will be approved when the criteria for the preferred peginterferon listed above are met AND ONE of the following is met: <ol style="list-style-type: none"> 1. The patient is currently being treated with the non-preferred agent OR 2. The patient has a history of a trial of the preferred peginterferon OR 3. The patient has an FDA labeled contraindication, documented intolerance, or hypersensitivity to the preferred peginterferon, OR 4. The prescriber has submitted documentation in support of the use of the non-preferred peginterferon, for the intended diagnosis which has been reviewed and approved by the Clinical Review pharmacist " ▪ Added Length of approval chart <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;">Genotype</th> <th style="width: 33%;">Combination Medication</th> <th style="width: 33%;">Length of Approval</th> </tr> </thead> <tbody> <tr> <td>1 or 4</td> <td>Pegylated interferon AND ribavirin</td> <td>12 weeks</td> </tr> <tr> <td>1</td> <td>Ribavirin ONLY</td> <td>24 weeks</td> </tr> <tr> <td>2</td> <td>Ribavirin</td> <td>12 weeks</td> </tr> <tr> <td>3</td> <td>Ribavirin</td> <td>24 weeks</td> </tr> <tr> <td>Hepatocellular Carcinoma -Pre-transplant</td> <td>Ribavirin</td> <td>48 weeks</td> </tr> </tbody> </table> <ul style="list-style-type: none"> ▪ Added to Items II A 1 and II A 2 "or Olysio" to read, "Incivek or Olysio" ▪ Added to Item II A 3 "for Incivek and < 25 IU/mL* or undetectable for Olysio" to read, "...with a viral load less than 1000 IU/mL* or undetectable for Incivek and < 25 IU/mL* or undetectable for Olysio" ▪ Revised Item II A 4 to change Incivek dosages from, "-750 mg 3 times a day (7-9 hours apart); -1125 mg 3 times a day (7-9 hours apart) if coadministration with efavirenz" to "-1125 mg 2 times a day (10-14 hours apart; -1500 mg 2 times a day (10-14 hours apart) if coadministration with efavirenz" and added, "Olysio:-150 mg once daily" ▪ Added to Item II A Length of Approval, "or Olysio" to read "Incivek or Olysio" ▪ Added to Items II B 1 "or Olysio" to read, "Incivek or Olysio" ▪ Added to Item II B 3 "or undetectable for Incivek and < 25 IU/mL* or undetectable for Olysio" to read, "with a viral load less than 1000 IU/mL* or undetectable for Incivek and < 25 IU/mL* or undetectable for Olysio" ▪ Updated Contraindicated Medications chart to add Olysio and Sovaldi. <p>Rationale section updated</p> <p>References updated</p>	Genotype	Combination Medication	Length of Approval	1 or 4	Pegylated interferon AND ribavirin	12 weeks	1	Ribavirin ONLY	24 weeks	2	Ribavirin	12 weeks	3	Ribavirin	24 weeks	Hepatocellular Carcinoma -Pre-transplant	Ribavirin	48 weeks
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02-11-2014	<ul style="list-style-type: none"> ▪ Updated Prior Authorization form link for Incivek Victrelis Olysio ▪ Established Prior Authorization form link for Sovaldi 																		
04-22-2014	<p>In Description section:</p> <ul style="list-style-type: none"> ▪ Description section II HEPATITIS C AGENTS – Through Preferred Hepatitis C Agents updated ▪ Dosing information updated <p>In Policy section II HEPATITIS C AGENTS - Through Preferred Hepatitis C Agents:</p> <ul style="list-style-type: none"> ▪ In I B Length of Approval added "and ribavirin" to read, "Incivek or Olysio plus peginterferon and ribavirin" and "Victrelis plus peginterferon and ribavirin" ▪ In I C Length of Approval added "and ribavirin" to read, "Triple therapy (peginterferon and ribavirin plus Incivek or Olysio)" and "Triple therapy (peginterferon and ribavirin plus Victrelis)" ▪ In I D Initial Evaluation – Sovaldi (sofosbuvir) replaced current language of: <ol style="list-style-type: none"> 1. The patient does not have any FDA labeled contraindications AND 2. ONE of the following: <ol style="list-style-type: none"> a. The patient has a diagnosis of hepatitis C genotype 2 or 3 confirmed by serological markers AND will receive concomitant ribavirin OR 																		

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	<p>b. The patient has a diagnosis of hepatitis C genotype 4 confirmed by serological markers AND will receive concomitant peginterferon alfa and ribavirin OR</p> <p>c. The patient has a diagnosis of hepatitis C genotype 1 confirmed by serological markers AND ONE of the following:</p> <ol style="list-style-type: none"> 1) The patient will receive concomitant peginterferon alfa and ribavirin OR 2) The patient is ineligible to receive peginterferon alfa AND will receive concomitant ribavirin <p>d. The patient has hepatitis C genotype 1 through 4 confirmed by serological markers and hepatocellular carcinoma AND ALL of the following:</p> <ol style="list-style-type: none"> 1) The patient is pre-transplant AND 2) ONE of the following: <ol style="list-style-type: none"> a) The patient has a single tumor 5 cm or less in diameter OR b) The patient has up to 3 tumors with each being 3 cm or less in diameter AND 3) The patient has NO extrahepatic manifestations of cancer or evidence of vascular invasion of tumor AND <p>3. The patient will NOT be receiving an NS3/4 A protease inhibitor (i.e. Incivek, Olysio, or Victrelis) at the same time as Sovaldi AND</p> <p>4. The dose is within the FDA labeled dose"</p> <p>WITH:</p> <ol style="list-style-type: none"> "1. The patient has a diagnosis of chronic hepatitis C infection confirmed by serological markers AND 2. Sofosbuvir will be used in a combination antiviral treatment regimen supported by FDA approved labeling or the AASLD guidelines (listed in Table 1 below) AND 3. The patient does NOT have any FDA labeled contraindications to sofosbuvir or the other agents used in the combination therapy AND 4. The patient will NOT be receiving Incivek (telaprevir) or Victrelis (boceprevir) concomitantly with sofosbuvir AND 5. If the patient has hepatocellular carcinoma the following are met: <ol style="list-style-type: none"> a. The patient has either a single tumor 5 cm or less in diameter OR The patient has up to 3 tumors with each being 3 cm or less in diameter AND b. The patient has NO extrahepatic manifestations of cancer or evidence of vascular invasion of tumor AND 6. The dosing of sofosbuvir is within the FDA labeled dosage (400 mg daily) AND 7. If the treatment regimen includes simeprevir, the dosing of simeprevir is within the FDA labeled dosage (150 mg daily)" <ul style="list-style-type: none"> ▪ For item I D, added Table 1 entitled "AASLD Supported Sovaldi Containing Antiviral Regimens" ▪ For item I D, added Table 2 which defines "INF ineligible" ▪ For item I D, replaced Length of approval table with Table 3 "Approval Duration" with the following columns: Genotype, Antiviral combination, and Length of Approval. ▪ In II A added "and ribavirin" to read in the sub-title, "Incivek or Olysio plus peginterferon and ribavirin" and in the introduction of the criteria, "Incivek or Olysio plus peginterferon and ribavirin will be approved..." ▪ In II B added "or Olysio" and "and ribavirin" to read in the sub-title, "Incivek or Olysio plus peginterferon and ribavirin" ▪ In II C and II D added "and ribavirin" to read, "Victrelis plus peginterferon and ribavirin"
	Rationale section updated
	References updated
06-15-2014	Policy posted August 12, 2014. Policy effective July 15, 2014.
	<p>In Description section:</p> <ul style="list-style-type: none"> ▪ Description section II HEPATITS C AGENTS – Through Preferred Hepatitis C Agents updated

REVISIONS																			
	<p>Dosing information updated</p> <p>In Policy section II HEPATITIS C AGENTS - Through Preferred Hepatitis C Agents:</p> <ul style="list-style-type: none"> ▪ In Item D 2 added "a. If genotype 1, treatment naïve requesting the combination of simeprivir and sofosbuvir, the patient has BOTH of the following: <ul style="list-style-type: none"> i. a METAVIR score of F3 (numerous septa, presumed fibrous) or F4 (cirrhosis) ii. Ineligible to receive peginterferon AND" ▪ In Table 1 added Genotype, Antiviral combination and SubGroup Designation for 1 HIV Coinfect, 1 Post Transplant, 2 Post Transplant. ▪ In Table 1 updated Genotype 5 or 6 adding an Antiviral combination ▪ In Table 1 added "or decompensated cirrhotics" to the Genotype to read, "1-4 with hepato-cellular carcinoma or decompensated cirrhotics" ▪ In Table 1 added asterisks to 2 and 3 meaning "Including HIV coinfecting patients" ▪ Following Table 2 added "including patients who have previously discontinued therapy with IFN due to adverse events (e.g. hypersensitivity, anaphylaxis, severe rash, severe anemias, etc.)." to correct and incomplete sentence. ▪ In Table 3 added Genotype, Antiviral combination and Length of Approval for 1 Post Transplant, 1 HIV Coinfect, 2 Post Transplant, 3 Post Transplant. ▪ In Table 3 updated Genotype 5 or 6 adding an Antiviral combination and related length of approval. ▪ In Table 3 added "or decompensated cirrhotics" to the Genotype to read, "1-4 with hepato-cellular carcinoma or decompensated cirrhotics" <p>In Rationale section:</p> <ul style="list-style-type: none"> ▪ Updated supporting clinical information. ▪ Added AASLD guidelines for special populations <p>References updated</p> <p>**The following Revision information, omitted at 06-15-2014 update, was added at the 10-28-2014 update:</p> <p>In Policy section II HEPATITIS C AGENTS – Through Preferred Hepatitis C Agents:</p> <ul style="list-style-type: none"> ▪ Removed the following criteria and Length of approval chart related to Initial Evaluation Nonpreferred peginterferon: <p>"E. Initial Evaluation Nonpreferred peginterferon will be approved when the criteria for the preferred peginterferon listed above are met AND ONE of the following is met:</p> <ol style="list-style-type: none"> 1. The patient is currently being treated with the non-preferred agent OR 2. The patient has a history of a trial of the preferred peginterferon OR 3. The patient has an FDA labeled contraindication, documented intolerance, or hypersensitivity to the preferred peginterferon, OR 4. The prescriber has submitted documentation in support of the use of the non-preferred peginterferon, for the intended diagnosis which has been reviewed and approved by the Clinical Review pharmacist <p>Length of approval:</p> <table border="1"> <thead> <tr> <th>Genotype</th> <th>Combination Medication</th> <th>Length of Approval</th> </tr> </thead> <tbody> <tr> <td>1 or 4</td> <td>Pegylated interferon AND ribavirin</td> <td>12 weeks</td> </tr> <tr> <td>1</td> <td>Ribavirin ONLY</td> <td>24 weeks</td> </tr> <tr> <td>2</td> <td>Ribavirin</td> <td>12 weeks</td> </tr> <tr> <td>3</td> <td>Ribavirin</td> <td>24 weeks</td> </tr> <tr> <td>Hepatocellular Carcinoma -Pre-transplant</td> <td>Ribavirin</td> <td>48 weeks"</td> </tr> </tbody> </table>	Genotype	Combination Medication	Length of Approval	1 or 4	Pegylated interferon AND ribavirin	12 weeks	1	Ribavirin ONLY	24 weeks	2	Ribavirin	12 weeks	3	Ribavirin	24 weeks	Hepatocellular Carcinoma -Pre-transplant	Ribavirin	48 weeks"
Genotype	Combination Medication	Length of Approval																	
1 or 4	Pegylated interferon AND ribavirin	12 weeks																	
1	Ribavirin ONLY	24 weeks																	
2	Ribavirin	12 weeks																	
3	Ribavirin	24 weeks																	
Hepatocellular Carcinoma -Pre-transplant	Ribavirin	48 weeks"																	
10-28-2014	<p>**Corrected Revision section 06-15-2014 to reflect portions of the Policy section that were deleted.</p> <p>In Description section II HEPATITIS C AGENTS:</p> <ul style="list-style-type: none"> ▪ In Description section header removed "Hepatitis C" and added "Pegylated Interferon" to read "Through Preferred Pegylated Interferon Agents" 																		

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	<ul style="list-style-type: none"> ▪ Updated description paragraph and FDA Approved Indications and Dosage chart to remove references to Incivek and Victrelis. ▪ Added to Target Drugs Oral Agents (NS3/4A protease inhibitors) chart "***" before Incivek and Victrelis and below the chart "***Retired, see appendix"
	<p>In II HEPATITIS C AGENTS Policy section:</p> <ul style="list-style-type: none"> ▪ In Item I B removed "protease inhibitor" and added "Olysio [simeprevir]" to read "(peginterferon, ribavirin, Olysio[simeprevir])". ▪ In Item I B added new 2 "The agent is being prescribed by a specialist or in consultation with a specialist". ▪ In Item I B 3 removed "an oral agent" and added "Olysio" to read "...triple therapy including Olysio peginterferon alfa..." ▪ In Item I B 7 removed dosing for Incivek and Victrelis. ▪ In Item I B 8 added "(e.g. Incivek, Olysio, Victrelis)". ▪ In Item I B 9 removed dosing duration for Incivek and Victrelis. ▪ In Item I B and I C Length of Approval removed information for Incivek and Victrelis. ▪ In Item I B removed "***HCV RNA level required at 8 weeks post first Victrelis dose (total treatment week 12) for evaluation of continued therapy." ▪ In Item I D added criteria of, "1. The patient is naïve to therapy with Sovaldi AND 2. The agent is being prescribed by a specialist or in consultation with a specialist AND" ▪ In Item I D removed "The patient will NOT be receiving Incivek (telaprevir) or Victrelis (boceprevir) concomitantly with sofosbuvir" ▪ In Table 1 Genotype 1 added "(regardless of subtype)" ▪ In Table 1 and Table 3 Genotype 1-4 with hepato-cellular carcinoma or decompensated cirrhotics removed "1-4 with" to read "hepato-cellular carcinoma or decompensated cirrhotics" ▪ In Item II A header, II A 1, II A 2, II B header, and II B 1, removed "Incivek or" ▪ In Item II A 3 and II B 3 removed "less than 1000 IU/mL* or undetectable for Incivek and" to read "...with a viral load < 25 IU/mL* or undetectable for Olysio" ▪ In Item II A 4 removed dosing for Incivek. ▪ In Item II A Length of Approval removed information for Incivek. ▪ In Item II A removed "***HCV RNA level required at 12 weeks post first Incivek dose for evaluation of continued peginterferon therapy." ▪ Removed the following criteria related to Victrelis: "C. Victrelis plus peginterferon and ribavirin First Renewal – at 16 weeks (total treatment duration) Victrelis plus peginterferon will be approved for renewal at 16 weeks when ALL of the following are met: 1. The patient has been previously approved for peginterferon and Victrelis AND 2. The patient's medication history indicates coadministration of peginterferon and ribavirin with Victrelis AND 3. The patient has had an HCV RNA level measured at 12 weeks (total treatment duration) with a viral load less than 100 IU/mL* or undetectable AND 4. The dose is within the FDA labeled or provisional guideline dosage for the requested oral agent: Victrelis: -800 mg 3 times a day (7-9 hours apart), starting after 4 weeks of peginterferon alfa and ribavirin therapy *Manufacturer recommends using the COBAS® TaqMan® assay when measuring HCV RNA levels. Length of Approval: Victrelis and peginterferon - 12 weeks *HCV RNA level required at 20 weeks post first Victrelis dose (24 weeks total treatment duration) for evaluation of continued therapy" and

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	<p>"D. Victrelis plus peginterferon and ribavirin Second Renewal – at 28 weeks (total treatment duration) Victrelis plus peginterferon will be approved for renewal at 28 weeks when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. The patient has been previously approved for peginterferon and Victrelis AND 2. The patient's medication history indicates coadministration of peginterferon and ribavirin with Victrelis AND 3. The patient has had an HCV RNA level measured at 24 weeks (total treatment duration) with a viral load less than 100 IU/mL* or undetectable AND 4. The dose is within the FDA labeled or provisional guideline dosage for the requested oral agent: Victrelis: -800 mg 3 times a day (7-9 hours apart), starting after 4 weeks of peginterferon alfa and ribavirin therapy <p>*Manufacturer recommends using the COBAS® TaqMan® assay when measuring HCV RNA levels. Length of Approval: Victrelis and peginterferon - 20 weeks"</p> <ul style="list-style-type: none"> ▪ In Contraindications chart removed reference to Incivek and Victrelis.
	Rationale section updated
	Coding section removed as codes are not used for pharmacy benefit.
	References updated
	Added an Hepatitis C Appendix section reflecting the retired Incivek®/telaprevir and Victrelis®/boceprevir) Prior Authorization Criteria.
02-24-2015	<ul style="list-style-type: none"> ▪ Title changed from "Hepatitis B / Oncology and Hepatitis C Agents (Pegasys®/Pegasys, Proclix®/peginterferon alfa-2a, PegIntron®/peginterferon alfa-2b, Incivek®/telaprevir, Olysio™/ simeprevir, Sovaldi™/sofosbuvir, and Victrelis®/boceprevir)" to "Hepatitis B / Oncology and Hepatitis C First Generation Agents (Pegasys®/Pegasys, Proclix®/peginterferon alfa-2a, PegIntron®/peginterferon alfa-2b and Olysio™/ simeprevir)" ▪ Related policy titles added under title. ▪ Removed PA forms for Incivek and Victrelis, and Sovaldi <p>In Description section II HEPATITIS C AGENTS:</p> <ul style="list-style-type: none"> ▪ Removed references to Sovaldi ▪ In Oral Agents and FDA Approved Indications and Dosage charts removed Sovaldi <p>In II HEPATITIS C AGENTS Policy section:</p> <ul style="list-style-type: none"> ▪ In I A removed "and" and added "plus" to read "peginterferon plus ribavirin" ▪ In I B 6 add "(simeprevir)" to read "For OLYSIO (simeprevir),..." ▪ In I B * corrected wording by removing "Incivek" and adding "Olysio" to read "...4 weeks post first Olysio dose..." ▪ Removed the following criteria for Initial Evaluation – Sovaldi (sofosbuvir) <ol style="list-style-type: none"> 1. The patient is naïve to therapy with Sovaldi AND 2. The agent is being prescribed by a specialist or in consultation with a specialist AND 3. The patient has a diagnosis of chronic hepatitis C infection confirmed by serological markers AND 4. Sofosbuvir will be used in a combination antiviral treatment regimen supported by FDA approved labeling or the AASLD guidelines (listed in Table 1 below) AND <ol style="list-style-type: none"> a. If genotype 1, treatment naïve requesting the combination of simeprevir and sofosbuvir, the patient has BOTH of the following: <ol style="list-style-type: none"> i. a METAVIR score of F3 (numerous septa, presumed fibrous) or F4 (cirrhosis) ii. Ineligible to receive peginterferon AND 5. The patient does NOT have any FDA labeled contraindications to sofosbuvir or the other agents used in the combination therapy AND 6. If the patient has hepatocellular carcinoma the following are met: <ol style="list-style-type: none"> a. The patient has either a single tumor 5 cm or less in diameter OR

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	<p>The patient has up to 3 tumors with each being 3 cm or less in diameter AND b. The patient has NO extrahepatic manifestations of cancer or evidence of vascular invasion of tumor AND</p> <p>7. The dosing of sofosbuvir is within the FDA labeled dosage (400 mg daily) AND 8. If the treatment regimen includes simeprevir, the dosing of simeprevir is within the FDA labeled dosage (150 mg daily)"</p> <ul style="list-style-type: none"> ▪ Removed AASLD Supported Sovaldi Containing Antiviral Regimens chart ▪ Removed IFN ineligible chart ▪ Removed Approval Duration Chart ▪ In II. Renewal Evaluations – TRIPLE THERAPY removed Sovaldi from Contraindications chart.
	Rationale section updated
	References updated
09-01-2015	<p>In I HEPATITIS B / Oncology Description section:</p> <ul style="list-style-type: none"> ▪ Updated to include adding Dosing information after the FDA Approved Indications and Dosage chart. <p>In I HEPATITIS B / Oncology Policy section:</p> <ul style="list-style-type: none"> ▪ In Items B and C removed "(for chronic hepatitis B infection)" and added "(not for oncology indication)" to read, "Pegasys (not for oncology indication) will be approved when the following are met:" and "PegIntron (not for oncology indication) will be approved when the following are met:" ▪ In Item C removed "The patient does not have any FDA labeled contraindications to therapy AND" ▪ In Length of Approval added "chronic" to read "18 months for confirmed chronic hepatitis B virus infection" and removed "Indefinite" and added "12 months" to read, "12 months for treatment of CML or oncology indication as supported by compendia" <p>In I HEPATITIS C AGENTS Description section: Updated to include adding the Discontinuation Rules for Hepatitis C Treatment Algorithm: Simeprevir.</p> <p>Rationale section updated to include updating to the 2015 American Association for the Study of Liver Diseases (AASLD) guidelines.</p> <p>In Revisions section:</p> <ul style="list-style-type: none"> ▪ Removed revision information for 03-28-2012, 07-01-2012, 01-01-2013. <p>References updated</p> <p>Appendix updated to remove reference and information related to Olysio.</p>
01-01-2016	<p>Policy published 12-30-2015. Policy effective 01-01-2016.</p> <p>In Policy Title added "Incivek/telaprevir" to drug list.</p> <p>In I HEPATITIS B / Oncology Description section:</p> <ul style="list-style-type: none"> ▪ Added to Hepatitis C Treatment Algorithm graph, reference notes. <p>In I HEPATITIS C AGENTS Description section:</p> <ul style="list-style-type: none"> ▪ To the Non-Preferred Target Drugs added: "Oral Agents (NS3/4A protease inhibitors), Incivek® (telaprevir)**, Olysio™ (simeprevir)#, Victrelis® (boceprevir)**" ▪ Added to Hepatitis C Treatment Algorithm graph, reference notes. <p>In I HEPATITIS C AGENTS Description section:</p> <ul style="list-style-type: none"> ▪ Removed "Initial Evaluation" from Items A, B, and C as it was repetitive to the header, which states "INITIAL EVALUATION" ▪ In Item B removed "Preferred Oral" and "Preferred" to read, "Olysio plus Peginterferon alfa (Pegasys) will be approved when ALL of the following are met:" ▪ In A Length of Duration removed "Olysio plus peginterferon and ribavirin - 8 weeks*" and "*HCV RNA level required at 4 weeks post first Olysio dose for evaluation of continued

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	<p>therapy" and added "Up to the duration as determined in table I below based on regimen and genotype" and a Treatment Duration Recommendations based on FDA labeling chart.</p> <ul style="list-style-type: none"> ▪ In Item C revised to current language from: "Nonpreferred peginterferon (PegIntron) (DUAL or TRIPLE THERAPY) will be approved when the criteria for the preferred peginterferon listed above are met AND ONE of the following is met: 1. The patient is currently being treated with the non-preferred agent (PegIntron) OR 2. The patient has a history of a trial of the preferred peginterferon (Pegasys) OR 3. The patient has an FDA labeled contraindication, documented intolerance, or hypersensitivity to the preferred peginterferon OR The prescriber has submitted documentation in support of the use of the non-preferred peginterferon for the intended diagnosis" ▪ In Item C Length of Approval removed "Triple therapy (peginterferon and ribavirin plus Olysio) = 8 weeks" ▪ Removed the section title "II. Renewal Evaluations – TRIPPLE THERAPY" ▪ In Item D revised to current language from: "A. Olysio plus peginterferon and ribavirin First Renewal – at 8 weeks (total treatment duration) Olysio plus peginterferon and ribavirin will be approved for renewal at 8 weeks when ALL of the following are met: 1. The patient has been previously approved for peginterferon and Olysio AND 2. The patient's medication history indicates coadministration of peginterferon and ribavirin with Olysio AND 3. The patient has had an HCV RNA level measured at 4 weeks (total treatment duration) with a viral load < 25 IU/mL* or undetectable for Olysio AND 4. The dose is within the FDA labeled or provisional guideline dosage for the requested oral agent: Olysio - 150 mg once daily *Manufacturer recommends using the COBAS® TaqMan® assay when measuring HCV RNA levels." ▪ In Item D Length of Approval removed "Olysio 4 weeks; peginterferon 8 weeks" and added "Dual therapy (peginterferon + ribavirin) = 24 months" ▪ Removed criteria for: "B. Olysio plus peginterferon and ribavirin Second Renewal – at 16 weeks (total treatment duration) Peginterferon will be approved for renewal at 16 weeks when ALL of the following are met: 1. The patient has been previously approved for peginterferon and Olysio AND 2. The patient's medication history indicates coadministration of peginterferon and ribavirin AND 3. The patient has had an HCV RNA level measured at 12 weeks (total treatment duration) with a viral load < 25 IU/mL* or undetectable for Olysio *Manufacturer recommends using the COBAS® TaqMan® assay when measuring HCV RNA levels. Length of Approval: peginterferon 32 weeks"
	Rationale section updated
	References updated
	Hepatitis C Appendix updated
06-01-2016	Published 05-25-2016. Effective 06-01-2016
	Title updated to remove drug names "(Pegasys/Pegasys, Proclick/peginterferon alfa-2a, PegIntron/peginterferon alfa-2b, Incivek/telaprevir, Olysio™/ simeprevir)"
	<p><u>I. HEPATITIS B / Oncology Description section:</u></p> <ul style="list-style-type: none"> ▪ Removed Simeprevir Discontinuation Rules and Dosing information as they applied to another portion of the policy.

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	<p><u>I. HEPATITIS B / Oncology Policy section:</u></p> <ul style="list-style-type: none"> ▪ Removed "Pegasys (not for oncology indication) will be approved when the following are met: <ol style="list-style-type: none"> 1. The patient does not have any FDA labeled contraindications to therapy" ▪ Removed "PegIntron (not for oncology indication) will be approved when the criteria for Pegasys listed above are met AND the following are met: <p>The patient is currently being treated with the non-preferred agent, PegIntron (peginterferon alfa-2b)"</p> <ul style="list-style-type: none"> ▪ In Item 3 added "If requesting a non-preferred peginterferon" to read "If requesting a non-preferred peginterferon, ONE of the following:"
	<p><u>II. HEPATITIS C AGENTS - Pegasys, PegIntron, and Olysio Description section</u></p> <ul style="list-style-type: none"> ▪ Removed Non-Preferred drugs Incivek (telaprevir) and Victrelis (boceprevir) as these are discussed in the Appendix. ▪ Updated FDA Approved Indications and Dosage chart for Olysio
	<p><u>II. HEPATITIS C AGENTS - Pegasys, PegIntron, and Olysio Policy section</u></p> <ul style="list-style-type: none"> ▪ Removed Dual Therapy (peginterferon plus ribavirin) criteria <p>"Preferred Peginterferon alfa (Pegasys) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. The patient does not have any FDA labeled contraindications to therapy AND 2. ONE of the following: <ol style="list-style-type: none"> a. The patient has a diagnosis of chronic hepatitis C, genotype 2, 3, 4-6 confirmed by serological markers OR b. The patient has a diagnosis of chronic hepatitis C, genotype 1, confirmed by serological markers and is requesting dual therapy (peginterferon alpha plus ribavirin) instead of triple therapy (oral agent, peginterferon alpha, and ribavirin) OR c. The patient has a diagnosis of chronic hepatitis C, genotype 1, confirmed by serological markers and is requesting continued dual therapy after discontinuation of NS3 / 4A protease inhibitor oral agent as part of a triple therapy regimen AND 3. The patient has NOT received 24 months or more of total peginterferon therapy <p>Length of Approval: 24 months"</p> <ul style="list-style-type: none"> ▪ In A 8 added "direct acting antiviral agent for treatment of hepatitis C (e.g. Daklinza, Harvoni, Incivek, Olysio, Sovaldi, Technivie, Victrelis, Viekira or Zepatier)" and removed "HCV NS3/4A protease inhibitor (e.g. Incivek, Olysio, or Victrelis)" to read "The patient has not attempted a prior course of therapy with a treatment regimen that includes the requested agent or any other direct acting antiviral agent for treatment of hepatitis C (e.g. Daklinza, Harvoni, Incivek, Olysio, Sovaldi, Technivie, Victrelis, Viekira or Zepatier)" ▪ In Item B added "Length of Approval: Up to the duration as determined in table I above based on regimen and genotype" ▪ Removed Nonpreferred peginterferon (DUAL) criteria: <p>"Nonpreferred peginterferon (DUAL) will be approved when the criteria for the preferred peginterferon listed above are met AND ONE of the following is met:</p> <ol style="list-style-type: none"> 1. The patient is currently being treated with the non-preferred agent OR 2. The patient has a history of a trial of the preferred peginterferon OR 3. The patient has an FDA labeled contraindication, documented intolerance, or hypersensitivity to the preferred peginterferon OR 4. The prescriber has submitted documentation in support of the use of the non-preferred peginterferon, for the intended diagnosis <p>Length of Approval: Dual therapy (peginterferon + ribavirin) = 24 months"</p> ▪ Updated the Contraindications chart for Olysio
	<p>Rationale section updated to include updating the AASLD recommendations removing priority treatment criteria</p>
	<p><u>Hepatitis C Appendix</u></p> <ul style="list-style-type: none"> ▪ Clinical Rationale section updated

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- Removed Initial Evaluation – DUAL THERAPY (peginterferon plus ribavirin):
"Preferred Peginterferon alfa will be approved when ALL of the following are met:
 1. The patient does not have any FDA labeled contraindications to therapy AND
 2. ONE of the following:
 - a. The patient has a diagnosis of chronic hepatitis C, genotype 2, 3, 4-6 confirmed by serological markers OR
 - b. The patient has a diagnosis of chronic hepatitis C, genotype 1, confirmed by serological markers and is requesting dual therapy (peginterferon alpha plus ribavirin) instead of triple therapy (oral agent, peginterferon alpha, and ribavirin) OR
 - c. The patient has a diagnosis of chronic hepatitis C, genotype 1, confirmed by serological markers and is requesting continued dual therapy after discontinuation of NS3/4A protease inhibitor oral agent as part of a triple therapy regimen AND
 3. The patient has NOT received 24 months or more of total peginterferon therapy
Length of Approval: 24 months"
- In Initial Evaluation – (Incivek or Victrelis plus peginterferon)
 - Added "(Incivek or Victrelis plus" and removed "TRIPLE THERAPY", "ribavirin, protease inhibitor)" and "Oral plus Preferred Peginterferon alfa" to read "Initial Evaluation – (Incivek or Victrelis plus peginterferon) will be approved when ALL of the following are met:"
 - In Item 6 added "direct acting antiviral agent for treatment of hepatitis C (e.g. Daklinza, Harvoni, Incivek, Olysio, Sovaldi, Technivie, Victrelis, Viekira or Zepatier)" and removed "HCV NS3/4A protease inhibitor" to read "The patient has not attempted a prior course of therapy with a treatment regimen that includes the requested agent or any other direct acting antiviral agent for treatment of hepatitis C (e.g. Daklinza, Harvoni, Incivek, Olysio, Sovaldi, Technivie, Victrelis, Viekira or Zepatier)"
- In Length of Approval revised Incivek plus peginterferon and ribavirin "8 weeks" to "up to 12 weeks" and Victrelis plus peginterferon and ribavirin "16 weeks" to "up to 44 weeks" and added "Peginterferon: Up to 48 weeks of continued therapy"
- Removed the following lab requirements
**Lab required at 4 weeks post first Incivek dose for evaluation of continued therapy
*Lab required at 8 weeks post first Victrelis dose (total treatment week 12) for evaluation of continued therapy"
- Added
"Non-preferred agent(s) (Incivek or Victrelis plus peg-interferon) will be approved when the criteria above are met AND ONE of the following is met:
 1. The patient is currently being treated with the non-preferred oral agent(s) and/or peg-interferon OR
 2. BOTH of the following:
 - a. If requesting a non-preferred peg-interferon, ONE of the following:
 - i. The patient has a history of a trial of the preferred peg-interferon OR
 - ii. The patient has an FDA labeled contraindication, documented intolerance, or hypersensitivity to the preferred peg-interferon agent AND
 - b. If requesting a non-preferred oral agent, the patient has an FDA labeled contraindication, documented intolerance, or hypersensitivity to the preferred oral agent"
 - Removed
"Initial Evaluation
Nonpreferred peginterferon (DUAL or TRIPLE THERAPY) will be approved when the criteria for the preferred peginterferon listed above are met AND ONE of the following is met:
 1. The patient is currently being treated with the non-preferred agent OR
 2. The patient has a history of a trial of the preferred peginterferon OR
 3. The patient has an FDA labeled contraindication, documented intolerance, or hypersensitivity to the preferred peginterferon, OR

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4. The prescriber has submitted documentation in support of the use of the non-preferred peginterferon, for the intended diagnosis which has been reviewed and approved by the Clinical Review pharmacist

Length of Approval: Dual therapy (peginterferon + ribavirin) = 24 months
 Triple therapy Peginterferon and ribavirin plus Incivek = 8 weeks
 Triple therapy Peginterferon and ribavirin plus Victrelis = 16 weeks"

- Removed

"Renewal Evaluations – TRIPLE THERAPY Incivek plus peginterferon and ribavirin First Renewal – at 8 weeks (total treatment duration)

Incivek plus peginterferon and ribavirin will be approved for renewal at 8 weeks when ALL of the following are met:

1. The patient has been previously approved for peginterferon and Incivek AND
2. The patients medication history indicates coadministration of peginterferon and ribavirin with Incivek AND
3. The patient has had an HCV RNA level measured at 4 weeks (total treatment duration) with a viral load less than 1000 IU/mL* or undetectable for Incivek AND

*Manufacturer recommends using the COBAS® TaqMan® assay when measuring HCV RNA levels.

4. The dose is within the FDA labeled or provisional guideline dosage for the requested oral agent:

Incivek – 1125 mg 2 times a day (10-14 hours apart); 1500 mg 2 times a day (10-14 hours apart) when coadministered with efavirenz

Length of Approval: Incivek - 4 weeks
 Peginterferon - 8 weeks

*Lab required at 12 weeks post first Incivek dose for evaluation of continued peginterferon therapy"

- Removed

"Incivek plus peginterferon and ribavirin Second Renewal – at 16 weeks (total treatment duration)

Peginterferon will be approved for renewal at 16 weeks when ALL of the following are met:

1. The patient has been previously approved for peginterferon and Incivek AND
2. The patients medication history indicates coadministration of peginterferon and ribavirin AND
3. The patient has had an HCV RNA level measured at 12 weeks (total treatment duration) with a viral load less than 1000 IU/mL* or undetectable for Incivek

*Manufacturer recommends using the COBAS® TaqMan® assay when measuring HCV RNA levels.

Length of Approval: peginterferon - 32 weeks"

- Removed

"Victrelis plus peginterferon and ribavirin First Renewal – at 16 weeks (total treatment duration)

Victrelis plus peginterferon will be approved for renewal at 16 weeks when ALL of the following are met:

1. The patient has been previously approved for peginterferon and Victrelis AND
2. The patients medication history indicates coadministration of peginterferon and ribavirin with Victrelis AND
3. The patient has had an HCV RNA level measured at 12 weeks (total treatment duration) with a viral load less than 100 IU/mL* or undetectable AND

*Manufacturer recommends using the COBAS® TaqMan® assay when measuring HCV RNA levels.

4. The dose is within the FDA labeled or provisional guideline dosage for the requested oral agent:

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	<p>Victrelis – 800 mg 3 times a day (7-9 hours apart), starting after 4 weeks of peginterferon alfa and ribavirin therapy Length of Approval: Victrelis and peginterferon - 12 weeks *Lab required at 20 weeks post first Victrelis dose (24 weeks total treatment duration) for evaluation of continued therapy"</p> <ul style="list-style-type: none"> ▪ Removed <p>"Victrelis plus peginterferon and ribavirin Second Renewal – at 28 weeks (total treatment duration) Victrelis plus peginterferon will be approved for renewal at 28 weeks when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. The patient has been previously approved for peginterferon and Victrelis AND 2. The patients medication history indicates coadministration of peginterferon and ribavirin with Victrelis AND 3. The patient has had an HCV RNA level measured at 24 weeks (total treatment duration) with a viral load less than 100 IU/mL* or undetectable AND <p>*Manufacturer recommends using the COBAS® TaqMan® assay when measuring HCV RNA levels.</p> <ol style="list-style-type: none"> 4. The dose is within the FDA labeled or provisional guideline dosage for the requested oral agent: <p>Victrelis – 800 mg 3 times a day (7-9 hours apart), starting after 4 weeks of peginterferon alfa and ribavirin therapy Length of Approval: Victrelis and peginterferon - 20 weeks"</p> <ul style="list-style-type: none"> ▪ Removed Contraindications chart for Incivek, Victrelis, Pegasys, PegIntron.
09-01-2016	<p>Title revised to Hepatitis B / Hepatitis C Peg-interferon – Through Preferred Agent(s)" from "Hepatitis B / Oncology and Hepatitis C First Generation Agents".</p> <p>Description section updated</p> <p>In Policy section:</p> <ul style="list-style-type: none"> ▪ Joined the Hepatitis B / Oncology and Hepatitis C sections together to be one set of criteria. ▪ Revised to current criteria from: <p>"I. HEPATITIS B / Oncology – Through Preferred Agent Pegasys or PegIntron will be approved when the following are met:</p> <ol style="list-style-type: none"> 1. The patient does not have any FDA labeled contraindications to therapy AND 2. ONE of the following: <ol style="list-style-type: none"> a. Peginterferon is being prescribed for the treatment of chronic myelogenous leukemia (CML) OR b. The use of the requested agent is for an oncology indication that is supported by compendia (NCCN Compendium™ level of evidence 1, 2A, or 2B, AHFS, DrugDex, Clinical Pharmacology) or the prescriber has submitted additional documentation supporting the requested therapeutic use c. BOTH of the following: <ol style="list-style-type: none"> i. Peginterferon is being requested prescribed for the treatment of chronic hepatitis B virus infection confirmed by serological markers AND ii. The patient has not been administered peginterferon for more than 18 months of total therapy AND 3. If requesting a non-preferred peginterferon, ONE of the following: <ol style="list-style-type: none"> a. The patient has a history of a trial and failure of the preferred peginterferon, Pegasys OR b. The patient has a contraindication to, intolerance of, or allergy to the preferred peginterferon, Pegasys OR c. The prescriber has submitted documentation in support of the use of the non-preferred peginterferon, PegIntron, for the intended diagnosis"

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	<p><u>and</u> "II. HEPATITIS C AGENTS (Pegasys, PegIntron, and Olysio) TRIPLE THERAPY (peginterferon, ribavirin, Olysio [simeprevir]) Olysio plus Peginterferon alfa (Pegasys) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. The patient has a diagnosis of chronic hepatitis C genotype 1 infection confirmed by serological markers AND 2. The agent is being prescribed by a specialist or in consultation with a specialist AND 3. The patient will receive triple therapy including Olysio, peginterferon alfa (Pegasys) and ribavirin AND 4. The patient has a compensated liver (no evidence of clinical disease (e.g. absence of encephalopathy, ascites, or bleeding)) AND 5. The patient does NOT have any FDA labeled contraindications, including coadministration with contraindicated medications (see table on page 9) AND 6. For OLYSIO (simeprevir), if the patient has subtype 1a, must NOT have the NS3 Q80K polymorphism AND 7. The dose is within the FDA labeled or provisional guideline dosage for the requested oral agent: Olysio - 150 mg once daily AND 8. The patient has not attempted a prior course of therapy with a treatment regimen that includes the requested agent or any other direct acting antiviral agent for treatment of hepatitis C (e.g. Daklinza, Harvoni, Incivek, Olysio, Sovaldi, Technivie, Victrelis, Viekira or Zepatier) AND 9. The patient has not been administered the requested agent for longer than the maximum FDA labeled duration for total therapy: Olysio – 12 weeks <p>Length of Approval: Up to the duration as determined in table I below based on regimen and genotype"</p> <ul style="list-style-type: none"> ▪ In Item B removed "Olysio plus" and added "drug specific" and "additional criteria" to read "Non-preferred peg-interferon will be approved when the drug specific criteria above and ONE of the following additional criteria are met:" ▪ In Item B 1 removed "oral agent(s) and/or" to read "The patient is currently being treated with the non-preferred peg-interferon" ▪ Removed "If requesting a non-preferred peg-interferon, ONE of the following:" and "If requesting a non-preferred oral agent, the patient has an FDA labeled contraindication, documented intolerance, or hypersensitivity to the preferred oral agent" ▪ In Item B 4 removed "and/or non-preferred peg-interferon, for the intended diagnosis" and added "over the preferred peg-interferon" to read "The prescriber has submitted documentation in support of the use of the non-preferred agent over the preferred peg-interferon" ▪ In Item B removed "Length of Approval: Up to the duration as determined in table I above based on regimen and genotype" ▪ Updated Table 1 Olysio, Peg-interferon (PEG-IFN), and Ribavirin Treatment Recommendations based on FDA Labeling ▪ Added "Table 2: Sovaldi + PEG-IFN + RBV Treatment Recommendations based on FDA approved labeling", "Table 3: Pegasys + RBV Treatment Recommendations based on FDA labeling", and "Table 4: PegIntron + RBV Treatment Recommendations based on FDA labeling" ▪ Updated the Contraindications chart
	Rationale section updated
	References updated
	Removed Hepatitis C Appendix for Victrelis (boceprevir) and Incivek (telaprevir).

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12-01-2017	<p>In Description section:</p> <ul style="list-style-type: none"> ▪ Removed preferred product language which required use of Pegasys before PegIntron. <p>In Policy section:</p> <ul style="list-style-type: none"> ▪ Removed the following non-preferred language "B. Non-preferred peg-interferon will be approved when the drug specific criteria above and ONE of the following additional criteria are met: <ol style="list-style-type: none"> 1. The patient is currently being treated with the non-preferred peg-interferon OR 2. The patient previously tried and failed the preferred peg-interferon OR 3. The patient has an intolerance, an FDA labeled contraindication or hypersensitivity to the preferred peg-interferon OR 4. The prescriber has submitted documentation in support of the use of the non-preferred agent over the preferred peg-interferon"
	Rationale updated
	References updated

REFERENCES

1. Pegasys prescribing information. July 2016.
2. PegIntron prescribing information. February 2016.
3. AASLD/IDSA HCV Guidance: Recommendations for Testing, Managing, and Testing Hepatitis C. Available at www.hcvguidelines.org. Accessed May 2017.
4. The center for Disease Control and Prevention. Viral Hepatitis Statistics and Surveillance. Available at <http://www.cdc.gov/hepatitis/statistics>. Accessed June 2016.
5. AASLD Guidelines for Treatment of Chronic Hepatitis B. https://www.aasld.org/sites/default/files/guideline_documents/hep28156.pdf. Accessed May 2017.