

Clinical Policy: Sofosbuvir/Velpatasvir (Epclusa)

Reference Number: GA.PMN.06

Effective Date: 12/16

Last Review Date: 7/2021

Line of Business: Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

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

FDA Approved Indication(s)

Epclusa is indicated for the treatment of adult and pediatric patients 6 years of age and older or weighing at least 17 kg with chronic HCV genotype 1, 2, 3, 4, 5, or 6 infection:

- Without cirrhosis or with compensated cirrhosis
- With decompensated cirrhosis for use in combination with ribavirin (RBV)

Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation[®] that Epclusa is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

*** Provider must submit documentation (including office chart notes and lab results) supporting that member has met all approval criteria ***

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

1. Diagnosis of chronic hepatitis C virus (HCV) infection as evidenced by detectable HCV ribonucleic acid (RNA) levels in the last 6 months;
2. Age \geq 6 years or weight \geq 17 kg;
3. Member must use authorized generic version of Epclusa, unless contraindicated or clinically significant adverse effects are experienced;
4. Confirmed HCV genotype is 1, 2, 3, 4, 5 or 6;
*Chart note documentation and copies of labs results are required
5. Documentation of the treatment status of the patient (treatment-naïve or treatment-experienced);
6. Documentation of cirrhosis status of the patient (no cirrhosis, compensated cirrhosis, or decompensated cirrhosis);
7. Life expectancy \geq 12 months with HCV treatment;
8. Prescribed regimen is consistent with an FDA or AASLD-IDSAs recommended regimen (*see Section III Dosage and Administration for reference*);
9. Member is hepatitis B virus (HBV) negative, or if positive, documentation that concurrent HBV infection is being treated (e.g., tenofovir alafenamide, adefovir,

- entecavir), unless contraindicated or clinically significant adverse effects are experienced (*see Appendix B*);
10. If prescribed with ribavirin, member has none of the following contraindications:
 - a. Pregnancy or possibility of pregnancy - member or partner;
 - b. Hypersensitivity to ribavirin;
 - c. Coadministration with didanosine;
 - d. Significant/unstable cardiac disease;
 - e. Hemoglobinopathy (e.g., thalassemia major, sickle cell anemia);
 - a. Hemoglobin < 8.5 g/dL.
 11. Dose does not exceed one of the following (a or b):
 - a. Adult and pediatric members with body weight \geq 30 kg: sofosbuvir/velpatasvir 400 mg/100 mg (1 tablet) per day;
 - b. Pediatric members with body weight 17 to 29 kg: sofosbuvir/velpatasvir 200 mg/50 mg (1 tablet) per day.

Approval duration: up to a total of 24 weeks*

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

B. Other diagnoses/indications: Refer to CP.PMN.53 – No Coverage Criteria/Off-Label Use Policy if diagnosis is NOT specifically listed under section I.

II. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AASLD: American Association for the Study of Liver Diseases	MRE: magnetic resonance elastography
APRI: AST to platelet ratio	NS3/4A, NS5A/B: nonstructural protein
CTP: Child Turcotte Pugh	Peg-IFN: pegylated interferon
CrCl: creatinine clearance	PI: protease inhibitor
FDA: Food and Drug Administration	RBV: ribavirin
FIB-4: Fibrosis-4 index	RNA: ribonucleic acid
HCC: hepatocellular carcinoma	
HCV: hepatitis C virus	
IDSA: Infectious Diseases Society of America	

Appendix B: Contraindications

- Epclusa and RBV combination regimen is contraindicated in patients for whom RBV is contraindicated. Refer to the RBV prescribing information for a list of contraindications for RBV.
- Box warning (s): risk of hepatitis B virus reactivation in patients co-infected with HCV and HBV

Appendix C: 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
Daklinza	Daclatasvir				
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 D: General Information

- Hepatitis B Virus (HBV) Reactivation is a black box warning for all direct-acting antiviral drugs for the treatment of HCV. HBV reactivation has been reported when treating HCV for patients co-infected with HBV, leading to fulminant hepatitis, hepatic failure, and death, in some cases. Patients should be monitored for HBV reactivation and hepatitis flare during HCV treatment and post-treatment follow-up, with treatment of HBV infection as clinically indicated.

III. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose	Reference
Genotype 1-6: Without cirrhosis or with compensated cirrhosis, treatment-naïve or treatment-experienced* patient	One tablet PO QD for 12 weeks	One tablet (Adult/Peds ≥ 30 kg: sofosbuvir 400 mg /velpatasvir 100 mg; Peds 17 to 29 kg: sofosbuvir 200 mg /velpatasvir 50 mg) per day	FDA-approved labeling
Genotype 1-6: With decompensated cirrhosis, treatment-naïve or treatment-experienced* patient	One tablet PO QD with weight-based RBV for 12 weeks (RBV-ineligible patient may use: one tablet PO QD for 24 weeks) [†]	One tablet (Adult/Peds ≥ 30 kg: sofosbuvir 400 mg /velpatasvir 100 mg; Peds 17 to 29 kg: sofosbuvir 200 mg /velpatasvir 50 mg) per day	FDA-approved labeling
Genotype 1-6: Treatment-naïve and treatment-experienced patients, post-liver transplant with compensated cirrhosis or without cirrhosis	One tablet PO QD for 12 weeks	One tablet (sofosbuvir 400mg /velpatasvir 100 mg) per day	FDA-approved labeling
Genotype 1-6: With decompensated cirrhosis in whom prior sofosbuvir- or NS5A inhibitor-based treatment failed	One tablet PO QD with weight-based RBV for 24 weeks [‡]	One tablet (sofosbuvir 400mg /velpatasvir 100 mg) per day	AASLD-IDSA (updated March 2021)
Genotype 1-6: Treatment-naïve and treatment-experienced patients, post-liver transplant with decompensated cirrhosis	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 400mg /velpatasvir 100 mg) per day	AASLD-IDSA (updated March 2021)
Genotype 3 with NS5A Y93H polymorphism: Treatment-naïve with compensated cirrhosis or treatment-experienced* without cirrhosis patient	One tablet PO QD with weight-based RBV for 12 weeks [‡]	One tablet (sofosbuvir 400mg /velpatasvir 100 mg) per day	AASLD-IDSA (updated March 2021)

AASLD/IDSA treatment guidelines for chronic hepatitis C infection are updated at irregular intervals; refer to the most updated AASLD/IDSA guideline for most accurate treatment regimen.

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

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

IV. Product Availability

Tablet: sofosbuvir 400mg with velpatasvir 100mg, sofosbuvir 200mg with velpatasvir 50mg

V. References

1. Epclusa Prescribing Information. Foster City, CA: Gilead Sciences, Inc.; July 2020. Available at http://www.gilead.com/~media/files/pdfs/medicines/liver-disease/epclusa/epclusa_pi.pdf?la=en. Accessed April 15, 2021.
2. American Association for the Study of Liver Diseases/ Infectious Disease Society of America (AASLD-IDSA). HCV guidance: recommendations for testing, managing, and treating hepatitis C. Last updated March 12, 2021. Available at: <https://www.hcvguidelines.org/>. Accessed April 15, 2021.
1. CDC. Hepatitis C Q&As for health professionals. Last updated August 7, 2020. Available at: <https://www.cdc.gov/hepatitis/hcv/hcvfaq.htm>. Accessed April 15, 2021.

Reviews, Revisions, and Approvals	Date	Plan Approval Date
New policy created, split from CP.PHAR.17 Hepatitis C Therapies policy. 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.” Methods to diagnose fibrosis/cirrhosis are modified to require a liver biopsy or a combination of one serologic and one radiologic test. Serologic and radiologic tests are updated and correlated with METAVIR per Appendix C. Dosing regimens are presented in Appendix. Criteria is added requiring a verification of HCV RNA status at 4 weeks (and again at 6 weeks if present at 4) accordingly, the initial approval period is shortened to 8 weeks.	07/16	07/16
Edited policy so congruent with the other HCV policies as follows: Testing criteria reorganized by cirrhosis status consistent with the regimen tables; HCC population broadened to incorporate those amenable to curative measures (resection, ablation, transplant). Fibrosure test that meets F3 requirement changed to ≥ 0.59. Criteria added excluding post-liver transplantation unless regimens specifically designate. Preferencing language edited for clarity. Removed creatinine clearance restriction. Under continuing approval, presence of HCV RNA is edited to remove specific timing of testing. Appendix B edited for clarity; Appendix C added. Appendix D – genotype “1” is footnoted to clarify possible subtypes.	08/16	09/16

Reviews, Revisions, and Approvals	Date	Plan Approval Date
“Includes HCC” is removed from the decompensated cirrhosis. “Daily” is removed from the “recommended regimen” column; presentation of other data is abbreviated/short-handed.		
Removed criteria regarding medication prescribed by a specialist Remove criteria regarding having HCC or advanced liver disease Removed criteria regarding medication adherence program Removed criteria regarding sobriety from alcohol/illicit drugs	9/16	9/2016
Added availability of full course of therapy as initial therapy consistent with appendix recommendation for initial criteria Removed continuation criteria	4/17	4/17
Added preferencing information requiring Mavyret for FDA-approved indications. Added information requiring Hep B screening for all patients prior to treatment to ensure that proper risk reduction measures are taken.	9/17	9/17
Annual review. No changes made.	3/18	3/18
Changed current Georgia policy templates to corporate standard templates for drug coverage criteria to meet corporate compliance. Changes/revisions included; new formatting, font size, use of standard policy language for each section of policy, and rearranged order of certain steps in criteria and sections. Added new preferred treatment tables that includes dosage and frequency based on genotype for Mavyret. Removed background sections. Updated general information and contraindication section to be consistent with corporate HCV policies.	2/21/19	2/19
Annual review. In the initial approval criteria, changed RNA detectable period from “over a 6 month period” to “in the last 6 months” for infection diagnosis.	10/19	10/19
Added preferencing for AG Eplcusa; Removed redirection to Mavyret based on contraindications criteria and all other information relative to Mavyret. Removed Appendix C for Metavir scoring. Updated order of all other Appendices. Updated references.	4/2020	4/2020
Added pediatric indication and dosing. References reviewed and updated.	7/2020	7/2020
Annual review. Added hepatitis B box warning to Appendix B Contraindications. Added Mayvret and Vosevi to Appendix D-Direct Acting Antivirals for Treatment of HCV infection and removed Olysio, Technivie, and Viekira XR as these were previously removed from the market. Updated Dosage and Administration table to include pediatric dosing when applicable, FDA-labeled dosing for post-liver transplant setting, references and grammatical updates. Added an additional tablet strength under product availability. Changed Centene Logo to PSHP Logo. References reviewed and updated.	4/2021	4/2021
Revised medical justification language for not using authorized generic version of Eplcusa to “must use” language; updated Section III table with AASLD recommended regimens; references reviewed and updated.	7/2021	7/2021

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.

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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.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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