

Clinical Policy: Sofosbuvir/Velpatasvir (Epclusa)

Reference Number: CP.PHAR.268

Effective Date: 07.16

Last Review Date: 08.23

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 3 years of age and older 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

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

I. Initial Approval Criteria

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

1. Diagnosis of chronic HCV infection as evidenced by detectable serum HCV RNA levels by quantitative assay in the last 6 months;
2. Member meets one of the following (a or b):
 - a. Member is treatment-naïve and does not have cirrhosis (i.e., eligible for simplified treatment regimen);
 - b. Confirmed HCV genotype is 1, 2, 3, 4, 5 or 6;***Chart note documentation and copies of lab results are required*
3. For genotype 3: One of the following (a or b):
 - a. Laboratory testing for the presence or absence of NS5A resistance-associated substitution (RAS) Y93H for velpatasvir if member meets one of the following scenarios (i or ii):
 - i. Member is treatment-naïve and has cirrhosis;
 - ii. Member has had previous HCV treatment and has no cirrhosis;
 - b. Member does not meet one of the above scenarios in 3a;
4. Member must use **authorized generic version of Epclusa**, unless contraindicated or clinically significant adverse effects are experienced;
5. Documentation of the treatment status of the member (treatment-naive or treatment-experienced);

6. Documentation of cirrhosis status of the member (no cirrhosis, compensated cirrhosis, or decompensated cirrhosis);
7. Age \geq 3 years;
8. Life expectancy \geq 12 months with HCV treatment;
9. Prescribed regimen is consistent with an FDA or AASLD-IDSAs recommended regimen (*see Section V Dosage and Administration for reference*);
10. Dose does not exceed one of the following (a, b, or c):
 - a. Adult and pediatric members with body weight \geq 30 kg: sofosbuvir/velpatasvir 400 mg/100 mg (1 tablet) per day;
 - b. Pediatric members 3 years of age and older with body weight $<$ 17 kg: sofosbuvir/velpatasvir 150 mg/37.5 mg per day;
 - c. Pediatric members 3 years of age and older with body weight 17 kg to $<$ 30 kg: sofosbuvir/velpatasvir 200 mg/50 mg 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)

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

1. Member must use **authorized generic version of Epclusa**, unless contraindicated or clinically significant adverse effects are experienced;
2. One of the following (a or b):
 - a. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (i or ii):
 - i. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
 - ii. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
 - b. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 2a above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

II. Continued Therapy

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

1. Member meets one of the following (a, b, or c):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
 - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
 - c. Documentation supports that member is currently receiving Epclusa for chronic HCV infection and has recently completed at least 60 days of treatment with Epclusa;
2. Member is responding positively to therapy;

3. Dose does not exceed one of the following (a, b, or c):
 - a. Adult and pediatric members with body weight ≥ 30 kg: sofosbuvir/velpatasvir 400 mg/100 mg (1 tablet) per day;
 - b. Pediatric members 3 years of age and older and body weight < 17 kg: sofosbuvir/velpatasvir 150 mg/37.5 mg per day;
 - c. Pediatric members 3 years of age and older and body weight 17 kg to < 30 kg: sofosbuvir/velpatasvir 200 mg/50 mg 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)

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

1. Member must use **authorized generic version of Epclusa**, unless contraindicated or clinically significant adverse effects are experienced;
2. One of the following (a or b):
 - a. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (i or ii):
 - i. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
 - ii. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
 - b. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 2a above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AASLD: American Association for the Study of Liver Diseases

FDA: Food and Drug Administration

HBV: hepatitis B virus

HCV: hepatitis C virus

HIV: human immunodeficiency virus

IDSA: Infectious Diseases Society of America

NS3/4A, NS5A/B: nonstructural protein

PegIFN: pegylated interferon

RBV: ribavirin

RAS: resistance-associated substitution

RNA: ribonucleic acid

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): 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.
- Boxed warning(s): risk of hepatitis B virus (HBV) reactivation in patients coinfecting 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 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

- 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.
- Child-Pugh Score:

	1 Point	2 Points	3 Points
Bilirubin	Less than 2 mg/dL Less than 34 umol/L	2-3 mg/dL 34-50 umol/L	Over 3 mg/dL Over 50 umol/L
Albumin	Over 3.5 g/dL Over 35 g/L	2.8-3.5 g/dL 28-35 g/L	Less than 2.8 g/dL Less than 28 g/L
INR	Less than 1.7	1.7 - 2.2	Over 2.2
Ascites	None	Mild / medically controlled	Moderate-severe / poorly controlled
Encephalopathy	None	Mild / medically controlled Grade I-II	Moderate-severe / poorly controlled. Grade III-IV

Child-Pugh class is determined by the total number of points: A = 5-6 points; B = 7-9 points; C = 10-15 points.

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

V. 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	Adult/Peds \geq 30 kg: sofosbuvir 400 mg /velpatasvir 100 mg (one tablet) 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) [†]	Peds 17 to < 30 kg: sofosbuvir 200 mg /velpatasvir 50 mg per day;	
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	Peds < 17 kg: sofosbuvir 150 mg /velpatasvir 37.5 mg per day	
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 October 2022)
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		

Indication	Dosing Regimen	Maximum Dose	Reference
	weeks (treatment experienced) [†]		
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 [‡]		

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.

**From clinical trials, treatment-experienced refers to previous treatment with NS3/4A protease inhibitor (telaprevir, boceprevir, or simeprevir) and/or peginterferon/RBV unless otherwise stated*

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

VI. Product Availability

- Tablets: sofosbuvir 400 mg with velpatasvir 100 mg, sofosbuvir 200 mg with velpatasvir 50 mg
- Oral pellets: sofosbuvir 200 mg with velpatasvir 50 mg, sofosbuvir 150 mg with velpatasvir 37.5 mg

VII. References

1. Epclusa Prescribing Information. Foster City, CA: Gilead Sciences, Inc.; April 2022. Available at: http://www.gilead.com/~media/files/pdfs/medicines/liver-disease/epclusa/epclusa_pi.pdf. Accessed April 17, 2023.
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 October 24, 2022. Available at: <https://www.hcvguidelines.org/>. Accessed May 5, 2023.
3. CDC. Hepatitis C Q&As for health professionals. Last updated August 7, 2020. Available at: <https://www.cdc.gov/hepatitis/hcv/hcvfaq.htm>. Accessed May 2, 2023.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2019 annual review: removed documented sobriety from alcohol and illicit IV drugs for ≥ 6 months prior to starting therapy; references reviewed and updated.	06.26.19	08.19
RT4: updated Mavyret dosing recommendations to 8 weeks total duration of therapy for treatment-naïve HCV with compensated cirrhosis across all genotypes (1-6).	10.03.19	
Added new prescriber requirement to include a “provider who has expertise in treating HCV based on a certified training program”; added preferencing for AG Epclusa; removed redirection to Mavyret based on contraindications criteria; Appendix F (Healthcare Provider HCV Training) added.	12.17.19	02.20

Reviews, Revisions, and Approvals	Date	P&T Approval Date
RT4: updated FDA indication and dosing for pediatric extension to age 6 years or weight \geq 17 kg.	04.02.20	
3Q 2020 annual review: no clinically significant changes; references reviewed and updated. RT4: added updated FDA-labeled dosing for post-liver transplant setting.	07.22.20	08.20
3Q 2021 annual review: revised medical justification language for not using authorized generic version of Eplcusa to “must use” language; updated Section V table with AASLD recommended regimens; RT4: updated criteria for Epclusa pediatric age expansion to 3 years and older along with pediatric dosing and new oral pellet dosage formulation; references reviewed and updated.	07.12.21	08.21
3Q 2022 annual review: no significant changes; references reviewed and updated.	05.05.22	08.22
Added criterion for NS5A RAS test for specific genotype 3 scenarios per AASLD recommendation. Template changes applied to other diagnoses/indications and continued therapy section.	08.30.22	
3Q 2023 annual review: added a bypass for HCV genotype documentation if member is treatment-naïve and does not have cirrhosis (i.e., eligible for AASLD-IDSIA simplified treatment regimen), also added accompanying rationale in Appendix E; removed prescriber specialty criterion per Medicaid plan requests; eliminated adherence program participation criterion due to competitor analysis; corrected genotype 3 lab test scenario from “and” to “or”; references reviewed and updated.	05.31.23	08.23

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.

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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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