Clinical Policy: Sofosbuvir/Velpatasvir/Voxilaprevir (Vosevi)

Reference Number: CP.PHAR.347
Effective Date: 09.17
Last Review: 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/voxilaprevir (Vosevi®) is a fixed-dose combination oral tablet. Sofosbuvir is a nucleotide analog hepatitis C virus (HCV) NS5B polymerase inhibitor, velpatasvir is an NS5A inhibitor, and voxilaprevir is an NS3/4A protease inhibitor.

FDA Approved Indication(s)

Vosevi is indicated for the treatment of adult patients with chronic HCV infection without cirrhosis or with compensated cirrhosis (Child-Pugh A) who have:

- Genotype 1, 2, 3, 4, 5, or 6 infection and have previously been treated with an HCV regimen containing an NS5A inhibitor*;
- Genotype 1a or 3 infection and have previously been treated with an HCV regimen containing sofosbuvir without an NS5A inhibitor**.
    - Additional benefit of Vosevi over sofosbuvir/velpatasvir was not shown in adults with genotype 1b, 2, 4, 5, or 6 infection previously treated with sofosbuvir without an NS5A inhibitor.

* In clinical trials, prior NS5A inhibitor experience included daclatasvir, elbasvir, ledipasvir, ombitasvir, or velpatasvir.
** In clinical trials, prior treatment experience included sofosbuvir with or without any of the following: peginterferon alfa/ribavirin, ribavirin, HCV NS3/4A protease inhibitor (boceprevir, simeprevir or telaprevir).

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 Vosevi 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, b, or c):
    a. HCV genotype is 1, 2, 3, 4, 5 or 6, and member has previously been treated with an HCV regimen containing one of the following NS5A inhibitors: daclatasvir, elbasvir, ledipasvir, ombitasvir, pibrentasvir, or velpatasvir;
    b. HCV genotype is 1a or 3, and member has previously been treated with an HCV regimen containing sofosbuvir with or without any of the following: peginterferon

alfa/ribavirin, ribavirin, HCV NS3/4A protease inhibitor (boceprevir, simeprevir or telaprevir);
   c. Member is treatment naïve and all of the following (i-iii):
      i. HCV genotype is 3;
      ii. Member has compensated cirrhosis;
      iii. Documentation for the presence of baseline NS5A resistance-associated substitution (RAS) Y93H for velpatasvir;

**Chart note documentation and copies of lab results are required*

3. If cirrhosis is present, confirmation of Child-Pugh A status;
4. Age ≥ 18 years;
5. For HCV treatment-experienced member: Member has received ≥ 8 weeks of the prior direct-acting antiviral agent (DAA) regimen from 2a or 2b above, unless virologic failure was determined prior to 8 weeks of therapy;
6. Member must use **Mavyret®** or **sofosbuvir/velpatasvir (Epclusa®) (*authorized generic preferred*)** as indicated below if member meets one of the following (a, b, c, or d), unless contraindicated or clinically significant adverse effects are experienced:
   a. For HCV genotype 1 and previous treatment with an HCV regimen containing an NS5A inhibitor without an NS3/4A protease inhibitor (i.e., Daklinza®, Epclusa®, Harvoni®): Member must use Mavyret;
   b. For HCV genotype 1a or 3 previous treatment with with an HCV regimen containing sofosbuvir with or without any of the following: peginterferon alfa/ribavirin, ribavirin, HCV NS3/4A protease inhibitor (boceprevir, simeprevir or telaprevir): Member must use Mavyret;
   c. For HCV genotype 1 through 6 and previous treatment with either Vosevi or Mavyret: Mavyret must be used in combination with Sovaldi® and RBV;
   d. For HCV genotype 3, treatment-naive, compensated cirrhosis with documentation of the presence of baseline NS5A RAS Y93H for velpatasvir: Member must use Epclusa (*authorized generic preferred*) in combination with RBV or Mavyret;
7. Life expectancy ≥ 12 months with HCV treatment;
8. Prescribed regimen is consistent with an FDA or AASLD-IDSA recommended regimen (*see Section V Dosage and Administration for reference*);
9. Dose does not exceed both of the following (a and b):
   a. Sofosbuvir 400 mg/velpatasvir 100 mg/voxilaprevir 100 mg per day;
   b. 1 tablet per day.

Approval duration: up to 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 **Mavyret** or **sofosbuvir/velpatasvir (Epclusa) (*authorized generic preferred*),** if applicable for the requested indication, unless clinically significant adverse effects are experienced or both are contraindicated;
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. Both of the following (i and ii):
      i. Documentation supports that member is currently receiving Vosevi for chronic HCV infection and has recently completed at least 60 days of treatment with Vosevi;
      ii. Member meets one of the following (1, 2, or 3):
         1) HCV genotype is 1, 2, 3, 4, 5 or 6, and member has previously been treated with an HCV regimen containing one of the following NS5A inhibitors: daclatasvir, elbasvir, ledipasvir, ombitasvir, pibrentasvir, or velpatasvir;
         2) HCV genotype is 1a or 3, and member has previously been treated with an HCV regimen containing sofosbuvir with or without any of the following: peginterferon alfa/ribavirin, ribavirin, HCV NS3/4A protease inhibitor (boceprevir, simeprevir or telaprevir);
         3) HCV genotype is 3, member is treatment-naïve with compensated cirrhosis, and documentation for the presence of baseline NS5A RAS Y93H for velpatasvir;
2. Member is responding positively to therapy;
3. Dose does not exceed both of the following (a and b):
   a. Sofosbuvir 400 mg/velpatasvir 100 mg/voxilaprevir 100 mg per day;
   b. 1 tablet per day.

Approval duration: up to a total treatment duration of 24 weeks*

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

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

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
DAA: direct-acting antiviral agent
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

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Mavyret® (glecaprevir/ pibrentasvir)	Treatment-experienced with IFN/pegIFN, RBV and/or sofosbuvir: **Genotypes 1, 2, 4, 5, or 6** Without cirrhosis: Three tablets PO QD for 8 weeks With compensated cirrhosis: Three tablets PO QD for 12 weeks	Mavyret: glecaprevir 300 mg/ pibrentasvir 120 mg (3 tablets) per day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Mavyret® (glecaprevir /pibrentasvir)	Treatment-experienced with IFN/pegIFN, RBV and/or sofosbuvir: **Genotype 3** Without cirrhosis or with compensated cirrhosis: Three tablets PO QD for 16 weeks	Mavyret: glecaprevir 300 mg/ pibrentasvir 120 mg (3 tablets) per day
Mavyret® (glecaprevir /pibrentasvir)	Treatment-experienced with NS5A inhibitor without prior NS3/4A protease inhibitor: **Genotype 1** Without cirrhosis or with compensated cirrhosis: Three tablets PO QD for 16 weeks	Mavyret: glecaprevir 300 mg/ pibrentasvir 120 mg (3 tablets) per day
Mavyret® (glecaprevir /pibrentasvir)	Treatment-experienced with NS3/4A protease inhibitor without prior NS5A inhibitor: **Genotype 1** Without cirrhosis or with compensated cirrhosis: Three tablets PO QD for 12 weeks	Mavyret: glecaprevir 300 mg/ pibrentasvir 120 mg (3 tablets) per day
Mavyret® (glecaprevir /pibrentasvir)	Treatment-naive: **Genotype 3** With compensated cirrhosis: Three tablets PO QD for 8 weeks	Mavyret: glecaprevir 300 mg/ pibrentasvir 120 mg (3 tablets) per day
sofosbuvir/ velpatasvir (Epclusa®) + RBV	Treatment-naive: **Genotype 3** With compensated cirrhosis and baseline NS5A RAS Y93H: sofosbuvir/velpatasvir 400 mg/100 mg + weight-based RBV for 12 weeks	sofosbuvir 400 mg /velpatasvir 100 mg (one tablet) per day
Mavyret®(glecaprevir /pibrentasvir) + Sovaldi® (sofosbuvir) + RBV	With prior sofosbuvir/velpatasvir/ voxilaprevir or prior glecaprevir/pibrentasvir treatment failure, with compensated cirrhosis or without cirrhosis **Genotypes 1-6**‡: Sovaldi 400 mg + Mavyret 300 mg/120 mg + weight-based RBV for 16 weeks	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.
ǂ Off-label, AASLD-IDSA guideline-supported dosing regimen

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): coadministration with rifampin
- Boxed warning(s): risk of hepatitis B virus (HBV) reactivation in patients coinfected with HCV and HBV

Appendix D: Direct-Acting Antivirals for Initial Treatment of HCV Infection

Brand Name	Drug Class				
	NS5A Inhibitor	Nucleotide Analog NS5B Polymerase Inhibitor	Non-Nucleoside NS5B Palm Polymerase Inhibitor	NS3/4A Protease Inhibitor (PI)	CYP3A Inhibitor
Epclusa*	Velpatasvir	Sofosbuvir			
Harvoni*	Ledipasvir	Sofosbuvir			
Mavyret*	Pibrentasvir			Glecaprevir	
Sovaldi		Sofosbuvir			
Viekira Pak*	Ombitasvir		Dasabuvir	Paritaprevir	Ritonavir
Vosevi*	Velpatasvir	Sofosbuvir		Voxilaprevir	
Zepatier*	Elbasvir			Grazoprevir	

**Combination drugs*

Appendix E: General Information

- 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.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose	Reference
Genotype 1-6: Treatment-experienced with NS5A inhibitor* with or without compensated cirrhosis	One tablet PO QD for 12 weeks	One tablet (sofosbuvir 400 mg/ velpatasvir 100 mg/ voxilaprevir 100 mg) per day	FDA-approved labeling
Genotype 1a or 3: Treatment-experienced with a sofosbuvir-containing regimen without NS5A inhibitor† with or without compensated cirrhosis	One tablet PO QD for 12 weeks		FDA-approved labeling
Genotype 1-6: Treatment-experienced with Mavyret® without cirrhosis	Vosevi one tablet PO QD for 12 weeks		AASLD-IDSA (updated October 2022)
Genotype 1-6: Treatment-experienced with Mavyret® with compensated cirrhosis	Vosevi one tablet PO QD with weight-based RBV for 12 weeks		AASLD-IDSA (updated October 2022)
Genotype 1-6: Treatment-experienced with Vosevi® with or without compensated cirrhosis	Vosevi one tablet PO QD with weight-based RBV for 24 weeks		AASLD-IDSA (updated October 2022)
Genotype 3: Treatment-naïve with compensated cirrhosis and baseline NS5A RAS Y93H	One tablet PO QD for 12 weeks		AASLD-IDSA (updated October 2022)

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.
** In clinical trials, prior NS5A inhibitor experience included daclatasvir, elbasvir, ledipasvir, ombitasvir, or velpatasvir*
† In clinical trials, prior treatment experience included sofosbuvir with or without any of the following: peginterferon alfa/ribavirin, ribavirin, HCV NS3/4A protease inhibitor (boceprevir, simeprevir, or telaprevir)

VI. Product Availability

Tablet: sofosbuvir 400 mg/velpatasvir 100 mg/voxilaprevir 100 mg

VII. References

1. Vosevi Prescribing Information. Foster City, CA: Gilead Sciences, Inc.; November 2019. Available at: www.vosevi.com. Accessed April 21, 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 September 29, 2021. Available at: https://www.hcvguidelines.org/. Accessed May 10, 2023.
3. Bourliere M, et al. Sofosbuvir, velpatasvir, and voxilaprevir for previously treated HCV infection. NEJM 2017;376:2134-46.
4. 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 5, 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
Added new prescriber requirement to include a "provider who has expertise in treating HCV based on a certified training program"; added Epclusa to Appendix B; Appendix F (Healthcare Provider HCV Training) added.	12.17.19	02.20
3Q 2020 annual review: added preferred re-direction for off-label Mavyret + Sovaldi + RBV after Vosevi failure; modified initial and continued approval durations up to 24 weeks to allow for post Vosevi failure off-label indication dosing per per AASLD/IDSA guideline; added Mavyret-specific contraindications for medical justification for inability to use Mavyret in appendix E; references reviewed and updated.	04.30.20	08.20
2Q 2021 annual review: updated criteria to include pibrentasvir as an acceptable option for previous treatment with an HCV regimen containing an NS5A inhibitor to align with appendix D table; references reviewed and updated.	02.09.21	05.21
3Q 2021 annual review: no significant changes; updated Appendix B therapeutic alternatives; removed the appendix E acceptable medical justification section for inability to use Mavyret as it overlaps with Vosevi clinical parameters for not using; references reviewed and updated.	05.04.21	08.21
3Q 2022 annual review: no significant changes; removed Appendix E unacceptable medical justification section for inability to use Mavyret as it overlaps with Vosevi warnings and removed reference to Appendix E from initial criteria; references reviewed and updated.	05.05.22	08.22
Added pathway to Vosevi approval for a specific treatment-naïve genotype 3 scenario per AASLD guideline with redirection to preferred Mavyret or Epclusa; clarified prior DAA regimen is a criterion for an HCV treatment-experienced member. Template changes applied to other diagnoses/indications and continued therapy section.	08.29.22	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2023 annual review: for criterion requiring preferred redirection of Mavyret, added clinical scenario of previous Mavyret failure per AASLD guidance; removed prescriber specialty criterion per Medicaid plan requests; eliminated adherence program participation criterion due to competitor analysis; corrected continued therapy other diagnoses section template verbiage to remove redirections; 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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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