PRIOR AUTHORIZATION POLICY

POLICY: Hepatitis C – Mavyret Prior Authorization Policy
- Mavyret® (glecaprevir/pibrentasvir tablets and oral pellets – AbbVie)

REVIEW DATE: 04/05/2023; selected revision 02/28/2024

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Mavyret, a direct-acting antiviral, contains glecaprevir, a pangenotypic NS3/4A protease inhibitor and pibrentasvir, a pangenotypic NS5A inhibitor.[1] It is indicated for the treatment of **chronic hepatitis C virus** (HCV) in the following scenarios:

- Patients ≥ 3 years of age with genotype 1, 2, 3, 4, 5, or 6 infection without cirrhosis or with compensated cirrhosis (Child-Pugh A).
- Patients ≥ 3 years of age with genotype 1 infection who have previously been treated with a regimen containing an HCV NS5A inhibitor or an NS3/4A protease inhibitor, but not both.

Dosing

The duration of therapy is based on prior treatment experience, genotype, and the presence or absence of cirrhosis (see Tables 1 and 2). In addition, Mavyret is recommended for 12 weeks in patients ≥ 3 years of age who are liver or kidney transplant recipients. Similar to non-transplant recipients, a 16-week treatment duration is recommended in genotype 1-infected patients who are NS5A inhibitor-experienced without prior treatment with an NS3/4A protease inhibitor or in genotype 3-infected patients who are treatment-experienced with regimens containing interferon, pegylated interferon, ribavirin, and/or Sovaldi® (sofosbuvir tablets/oral pellets).

Table 1. Recommended Duration for Treatment-Naïve Patients.[1]

HCV Genotype	Treatment Duration	
	No Cirrhosis	Compensated Cirrhosis (Child-Pugh A)
1, 2, 3, 4, 5, or 6	8 weeks	8 weeks

HCV – Hepatitis C virus.

Table 2. Recommended Duration for Treatment-Experienced Patients.[1]

HCV Genotype	Prior Treatment Experience	Duration	
		Without Cirrhosis	With Compensated Cirrhosis (Child-Pugh A)
1, 2, 4, 5, 6	PRS	8 weeks	12 weeks
3	PRS	16 weeks	16 weeks
1	NS3/4 PI[1] (NS5A-naïve)	12 weeks	12 weeks
	NS5A inhibitor[2] (NS3/4 PI-naïve)[†]	16 weeks	16 weeks

HCV – Hepatitis C virus; PRS – Prior treatment experience with regimens containing interferon, pegylated interferon, ribavirin, and/or Sovaldi® (sofosbuvir tablets), but no prior treatment experience with an HCV NS3/4A protease inhibitor (PI) or NS5A inhibitor; PI – Protease inhibitor; [1] Regimens containing Olysio® (simeprevir capsules) and Sovaldi, or Olysio, Victrelis® (boceprevir capsules), or Incivek® (telaprevir tablets) with interferon or pegylated interferon and ribavirin were studied; [2] Regimens containing ledipasvir/sofosbuvir or Daklinza® (daclatasvir tablets) + pegylated interferon + ribavirin [unapproved regimen] were studied.

Guidelines

The American Association for the Study of Liver Diseases/Infectious Diseases Society of America (AASLD/IDSA) provide recommendations for testing, monitoring, and treating HCV (October 24, 2022).[2] Instances in which the guidelines provide recommendations for Mavyret outside of the FDA-approved indications are outlined below.

With the availability of pangenotypic HCV treatment regimens, HCV genotyping is no longer required prior to treatment initiation for all individuals. Pretreatment genotyping is still recommended in patients with cirrhosis and/or past unsuccessful HCV treatment, because treatment regimens may differ by genotype. However, for treatment-naïve patients without cirrhosis, although genotyping may impact the preferred treatment approach, it is not required if a pangenotypic regimen is used. Treatment-naïve adults without cirrhosis are eligible for simplified treatment if they do not have hepatitis B virus (not hepatitis B serum antigen [HBsAg] positive), are not pregnant, do not have hepatocellular carcinoma, and have not had a liver transplantation. In treatment-naïve adults without cirrhosis, the recommended regimens are Mavyret for 8 weeks or sofosbuvir/velpatasvir for 12 weeks. Additional genotype-specific and/or special circumstance-specific recommendations are also provided for patients falling outside of these parameters.

Mavyret is recognized as a recommended regimen (12 weeks) for the treatment of patients with recurrent HCV post-liver transplantation (without cirrhosis or with compensated cirrhosis).

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Mavyret. All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of patients treated with Mavyret as well as the monitoring required for adverse events and efficacy, approval requires Mavyret to be prescribed by or in consultation with a physician who specializes in the condition being treated.

- **Mavyret® (glecaprevir/pibrentasvir tablets and oral pellets (AbbVie)**

is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indications

1. **Chronic Hepatitis C Virus (HCV) Genotype 1, 2, 3, 4, 5, or 6, Treatment-Naïve.** Approve for 8 weeks if the patient meets the following (A, B, and C):
   - **A)** Patient is ≥ 3 years of age; AND
   - **B)** Patient is HCV treatment-naïve (the patient has not previously received treatment for their chronic HCV infection); AND
   - **C)** The medication is prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician.

2. **Chronic Hepatitis C Virus (HCV), Genotype 1, Treatment-Experienced.** Approve for the duration noted if the patient meets the following (A, B, and C):
   - **A)** Patient is ≥ 3 years of age; AND
   - **B)** Patient meets ONE of the following conditions (i, ii, iii, or iv):
     - **i.** NS5A-Experienced, NS34-Naïve: Approve for 16 weeks if the patient meets the following (a, b, and c):
       - **a)** Patient does not have cirrhosis or has compensated cirrhosis (Child-Pugh A); AND
       - **b)** Patient had a prior null response, prior partial response, or had relapse after prior treatment with one of the following NS5A-inhibitor containing products: Daklinza (daclatasvir tablets), sofosbuvir/velpatasvir, ledipasvir/sofosbuvir; AND
       - **c)** Patient has not previously been treated with one of the following NS3/4A inhibitor or NS3/4A inhibitor-containing products: Olysio (simeprevir capsules), Victrelis (boceprevir capsules), or Incivek (telaprevir tablets), Technivie (ombitasvir/paritaprevir/ritonavir tablets), Viekira Pak (ombitasvir/paritaprevir/ritonavir tablets; dasabuvir tablets, co-packaged), Viekira XR (dasabuvir/ombitasvir/paritaprevir/ritonavir extended-release tablets), Vosevi (sofosbuvir/velpatasvir/voxilaprevir tablets); or Zepatier (elbasvir/grazoprevir tablets); OR

ii. NS3/4-Experienced, NS5A-Naïve: Approve for 12 weeks if the patient meets the following (a, b, and c):
- **a)** Patient does not have cirrhosis or has compensated cirrhosis (Child-Pugh A); AND
- **b)** Patient has not previously been treated with one of the following NS5A-inhibitor-containing products: Daklinza (daclatasvir tablets), sofosbuvir/velpatasvir, ledipasvir/sofosbuvir, Technivie (ombitasvir/paritaprevir/ritonavir tablets), Viekira Pak (ombitasvir/paritaprevir/ritonavir tablets; dasabuvir tablets, co-packaged), Viekira XR (dasabuvir/ombitasvir/paritaprevir/ritonavir extended-release tablets), Vosevi (sofosbuvir/velpatasvir/voxilaprevir tablets), or Zepatier (elbasvir/grazoprevir tablets); AND
- **c)** Patient had a prior null response, prior partial response, or had relapse after prior treatment with one of the following NS3/4A inhibitor or NS3/4A inhibitor-containing products: Olysio (simeprevir capsules), Victrelis (boceprevir capsules), or Incivek (telaprevir tablets); OR

iii. Pegylated Interferon/Interferon, Ribavirin, Sovaldi-Experienced: Approve for 8 weeks if the patient meets the following (a and b):
- **a)** Patient does not have cirrhosis; AND
- **b)** Patient had a prior null response, prior partial response, or had relapse after prior treatment with one of the following regimens: interferon ± ribavirin, pegylated interferon ± ribavirin, Sovaldi (sofosbuvir tablets/oral pellets) + ribavirin, Sovaldi + pegylated interferon + ribavirin; OR

iv. Pegylated Interferon/Interferon, Ribavirin, Sovaldi-Experienced: Approve for 12 weeks if the patient meets the following (a and b):
- **a)** Patient has compensated cirrhosis (Child-Pugh A); AND
- **b)** Patient had a prior null response, prior partial response, or had relapse after prior treatment with one of the following regimens: interferon ± ribavirin, pegylated interferon ± ribavirin, Sovaldi (sofosbuvir tablets/oral pellets) + ribavirin, Sovaldi + pegylated interferon + ribavirin; AND

C) The medication is prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician

3. Chronic Hepatitis C Virus (HCV), Genotype 2, 4, 5, or 6, Treatment-Experienced. Approve for the duration noted if the patient meets the following (A, B, and C):

A) Patient is ≥ 3 years of age; AND

B) Patient meets ONE of the following (i or ii):

i. Approve for 8 weeks if the patient meets the following (a and b):
- **a)** Patient does not have cirrhosis; AND
- **b)** Patient had a prior null response, prior partial response, or had relapse after prior treatment with one of the following regimens: interferon ± ribavirin, pegylated interferon ± ribavirin, Sovaldi (sofosbuvir tablets/oral pellets)+ ribavirin, Sovaldi + pegylated interferon + ribavirin; OR

ii. Approve for 12 weeks if the patient meets the following (a and b):

a) Patient has compensated cirrhosis (Child-Pugh A); AND

b) Patient had a prior null response, prior partial response, or had relapse after prior treatment with one of the following regimens: interferon ± ribavirin, pegylated interferon ± ribavirin, Sovaldi (sofosbuvir tablets/oral pellets) + ribavirin, Sovaldi + pegylated interferon + ribavirin; AND

C) The medication is prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician.

4. **Chronic Hepatitis C Virus (HCV), Genotype 3, Treatment-Experienced**. Approve for 16 weeks if the patient meets the following (A, B, C, and D):

A) Patient is ≥ 3 years of age; AND

B) Patient does not have cirrhosis or has compensated cirrhosis (Child-Pugh A); AND

C) Patient had a prior null response, prior partial response, or had relapse after prior treatment with one of the following regimens: interferon ± ribavirin, pegylated interferon ± ribavirin, Sovaldi (sofosbuvir tablets/oral pellets) + ribavirin, Sovaldi + pegylated interferon + ribavirin; AND

D) The medication is prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician.

5. **Hepatitis C Virus (HCV) Kidney or Liver Transplant Recipient, Genotype 1, 2, 3, 4, 5, or 6**. Approve for the duration noted if the patient meets the following (A, B, C, and D):

A) Patient is ≥ 3 years of age; AND

B) Patient is a kidney or liver transplant recipient with HCV; AND

C) Patient meets ONE of the following (i, ii, or iii):

i. Patient has genotype 2, 4, 5, or 6 HCV: Approve for 12 weeks; OR

ii. Patient has genotype 1 HCV: Approve for the duration below (a or b):

a) NS5A-Experienced, NS3/4-Naïve: Approve for 16 weeks if the patient meets the following ([1] and [2]):

(1) Patient had a prior null response, prior partial response, or had relapse after prior treatment with one of the following NS5A-inhibitor containing products: Daklinza (daclatasvir tablets), sofosbuvir/velpatasvir, ledipasvir/sofosbuvir; AND

(2) Patient has not previously been treated with one of the following NS3/4A inhibitor or NS3/4A inhibitor-containing products: Olysio (simeprevir capsules), Victrelis (boceprevir capsules), or Incivek (telaprevir tablets), Technivie (ombitasvir/paritaprevir/ritonavir tablets), Viekira Pak (ombitasvir/paritaprevir/ritonavir tablets; dasabuvir tablets, co-packaged), Viekira XR (dasabuvir/ombitasvir/paritaprevir/ritonavir extended-release tablets), Vosevi (sofosbuvir/velpatasvir/voxilaprevir tablets); or Zepatier (elbasvir/grazoprevir tablets). OR

b) Approve for 12 weeks for all other patients with genotype 1 HCV; OR

iii. Patient has genotype 3 HCV: Approve for the duration below (a or b):

a) Approve for 16 weeks if the patient had a prior null response, prior partial response, or had relapse after prior treatment with one of the

following regimens: interferon ± ribavirin, pegylated interferon ± ribavirin, Sovaldi (sofosbuvir tablets/oral pellets) + ribavirin, Sovaldi + pegylated interferon + ribavirin; OR

b) Approve for 12 weeks for all other patients with genotype 3 HCV; AND

D) The medication is prescribed by or in consultation with one of the following prescribers who is affiliated with a transplant center: gastroenterologist, hepatologist, infectious diseases physician, nephrologist, renal transplant physician, or liver transplant physician.

Other Uses with Supportive Evidence

6. **Chronic Hepatitis C Virus (HCV), Genotype Unknown/Undetermined.** Approve for 8 weeks if the patient meets the following (A, B, C, D, E, F, G, and H):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient does not have cirrhosis; AND
   - **C)** Patient has not previously been treated for hepatitis C virus; AND
   - **D)** Patient does not have hepatitis B virus; AND
   - **E)** Patient is not pregnant; AND
   - **F)** Patient does not have hepatocellular carcinoma; AND
   - **G)** Patient has not had a liver transplantation; AND
   - **H)** The medication will be prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician.

7. **Recurrent Hepatitis C Virus (HCV) Post-Liver Transplantation, Genotype 1, 2, 3, 4, 5, or 6.** Approve for 12 weeks if the patient meets the following (A, B, and C):
   - **A)** Patient is ≥ 3 years of age; AND
   - **B)** Patient has recurrent HCV after a liver transplantation; AND
   - **C)** The medication is prescribed by or in consultation with one of the following prescribers who is affiliated with a transplant center: a gastroenterologist, hepatologist, infectious diseases physician, or liver transplant physician.

8. **Patient Has Been Started on Mavyret.** Approve for an indication or condition addressed as an approval in the Recommended Authorization Criteria section (FDA-Approved Indications or Other Uses with Supportive Evidence). Approve the duration described above to complete a course therapy (e.g., a patient who should receive 12 weeks, and has received 3 weeks should be approved for 9 weeks to complete their 12-week course).

CONDITIONS NOT COVERED

- **Mavyret® (glecaprevir/pibrentasvir tablets and oral pellets (AbbVie) is(are) considered experimental, investigational or unproven for ANY other use(s) including the following (this list may not be all inclusive; criteria will be updated as new published data are available):**

1. **Hepatitis C Virus (HCV) Child-Pugh Class B or C Liver Disease (Moderate or Severe Hepatic Impairment).** Mavyret is contraindicated in patients with moderate or severe hepatic impairment (Child-Pugh Class B or C).

2. **Hepatitis C Virus (HCV) [any genotype], Combination with Any Other Direct-Acting Antivirals**. Mavyret provides a complete antiviral regimen.

3. **Pediatric Patient (< 3 Years of Age).** The safety and efficacy of Mavyret have not been established in pediatric patients < 3 years of age.[1]

REFERENCES

1. Mavyret® tablets and oral pellets [prescribing information]. North Chicago, IL: AbbVie; September 2021.
2. American Association for the Study of Liver Diseases and the Infectious Diseases Society of America. Testing, managing, and treating hepatitis C. Available at: http://www.hcvguidelines.org. Updated October 24, 2022. Accessed on March 24, 2023.

HISTORY

Type of Revision	Summary of Changes	Review Date
Early Annual Revision	Mavyret oral pellets were added to the policy. Throughout the policy, where listed, "Epclusa (brand or generic)" was changed to "sofosbuvir/velpatasvir" and "Harvoni (brand or generic)" was changed to "ledipasvir/sofosbuvir". **Chronic Hepatitis C Virus (HCV) Genotype 1, 2, 3, 4, 5, or 6, Treatment-Naïve:** Age of approval was changed to ≥ 3 years of age. **Chronic Hepatitis C Virus (HCV), Genotype 1, Treatment-Experienced:** Age of approval was changed to ≥ 3 years of age. **Chronic Hepatitis C Virus (HCV), Genotype 2, 4, 5, or 6, Treatment-Experienced:** Age of approval was changed to ≥ 3 years of age. **Chronic Hepatitis C Virus (HCV), Genotype 3, Treatment-Experienced:** Age of approval was changed to ≥ 3 years of age. **Hepatitis C Virus (HCV) Kidney or Liver Transplant Recipient, Genotype 1, 2, 3, 4, 5, OR 6**. Age of approval was changed to ≥ 3 years of age. The prescriber list was updated to require the prescriber to be affiliated with a transplant center, and the list of prescribers was updated to add a nephrologist and a renal transplant physician. **Recurrent Hepatitis C Virus (HCV) Post-Liver Transplantation, Genotype 1, 2, 3, 4, 5, or 6:** Age of approval was changed to ≥ 3 years of age. **Pediatric Patients (Age < 12 Years or < 45 kg):** The age was revised to < 3 years of age and weight was removed from this "Condition not Recommended for Approval".	06/16/2021
Annual Revision	No criteria changes.	06/08/2022
Early Annual Revision	**Chronic Hepatitis C Virus (HCV), Genotype Unknown/Undetermined:** A new condition of coverage was added to "Other Uses with Supportive Evidence". Patients meeting these criteria are approved for 8 weeks of Mavyret.	04/05/2023
Selected Revision	**Conditions Not Covered : Life Expectancy Less Than 12 Months Due to Non-Liver Related Comorbidities**. This condition was removed.	02/28/2024