

Clinical Policy: Hepatitis B Drugs

Reference Number: AZ.CP.PHAR.03

Effective Date: 11.16.16

Last Review Date: 08.18

Line of Business: Arizona Medicaid

[Revision Log](#)

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

Description

The following are antiviral medications for the treatment of Hepatitis B requiring prior authorization: Entecavir (Baraclude™), adefovir (Hepsera®)

FDA approved indications:

- Baraclude is indicated for the treatment of chronic hepatitis B virus infection in adults and children at least two years of age with evidence of active viral replication and either evidence of persistent elevations in serum aminotransferases (ALT or AST) or histologically active disease.
- Hepsera is indicated for the treatment of chronic Hepatitis B in adults and children 12 years of age and older.

Policy/Criteria

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

It is the policy of health plans affiliated with Centene Corporation® that Baraclude, Hepsera are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Hepatitis B Virus Infection (must meet all):

1. Diagnosis of Hepatitis B infection;
2. Prescribed by or in consultation with a gastroenterologist, hepatologist or infectious disease specialist;
3. Dose does not exceed the FDA-approved maximum recommended dose for the particular drug.

Approval duration: One year

B. Other diagnoses/indications

1. Refer to CP.PHAR.57 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized)

II. Continued Therapy

A. Hepatitis B Virus Infection (must meet all):

1. Currently receiving medication via a health plan affiliated with Centene Corporation or member has previously met initial approval criteria;

CLINICAL POLICY

Hepatitis B Drugs

2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed FDA-approved maximum recommended dose for the particular drug.

Approval duration: One year

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via a health plan affiliated with Centene Corporation and documentation supports positive response to therapy.

Approval duration: Duration of request or 6 months (whichever is less); or

2. Refer to CP.PHAR.57 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized)

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 policy – CP.PHAR.57 or evidence of coverage documents

IV. Appendices/General Information

Appendix A: General Information

- A Patient co-infected with HIV should be evaluated by an HIV specialist to see if he/she needs to be treated with a HAART regimen that includes a component with activity against HBV (e.g. Viread[®]-tenofovir, Epivir[®]-lamivudine, or Emtriva[®]-emtricitabine).
- According to American Gastroenterological Association (AGA), recommendations on the treatment of chronic hepatitis B (HBV) are as follows:
 - HBV DNA results should be reported in IU/mL (1 IU/mL = 5.6 copies/mL)
 - The upper limit of normal for serum ALT concentrations for men and women are 30 IU/L and 19 IU/L, respectively.
 - Lamivudine is not recommended for first line use EXCEPT in the following: a) in patients receiving short-term antiviral prophylaxis during chemotherapy or in pregnancy, b) as part of an HIV regimen in patient with HBV/HIV co-infection, or c) in combination with adefovir in patients with hepatic decompensation.
- Patients requiring therapy for longer than 1 year probably are best treated with Baraclude, Hepsera or Tyzeka, which have much lower incidence rates of resistance when compared to Epivir HBV. Although still listed as formulary on the AHCCCS Drug List, Tyzeka is going off-market with an obsolete date of 11/30/18 per CVS Caremark.
- Prevention of resistance may be a greater benefit of combination therapy than enhanced potency; however, large well-designed studies are needed to confirm this concept. There is insufficient robust data to approve coverage of combination use.

Appendix B: Therapeutic Alternatives

CLINICAL POLICY

Hepatitis B Drugs

Drug	Dosing Regimen	Dose Limit/ Maximum Dose
Tenofovir disoproxil fumarate (Viread)	300 mg PO QD For CrCl 30-49 ml/min: 300 mg PO Q 48 hours For CrCl 10-29 ml/min: 300 PO mg Q 72-96 hours For patients on hemodialysis: 300 mg PO Q 7 days or approximately 12 hours after dialysis	300 mg daily
Lamivudine (Epivir HBV)	Adults: 100 mg PO QD Pediatric patients age 2-17: 3 mg/kg, up to 100 mg QD Adjust dose in renal impairment	100 mg daily

Viread and Epivir HBV do not require Prior Authorization.

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.

V. Dosage and Administration

Drug Name	Dosing Regimen	Maximum Dose
Entecavir (Baraclude)	<u>Lamivudine-naïve patients:</u> 0.5 mg PO QD CrCl 30-49 ml/min: 0.25mg PO QD CrCl 10-29 ml/min: 0.15 mg PO QD Hemodialysis: 0.05 mg PO following hemodialysis <u>Lamivudine-experienced:</u> 1 mg PO QD CrCl 30-49 ml/min: 0.5 mg PO QD CrCl 10-29 ml/min: 0.3 mg PO QD Hemodialysis: 0.1 mg PO QD	1 mg daily
Adefovir (Hepsera)	10 mg PO QD CrCl 30-49 ml/min: 10 mg PO Q 48h CrCl 10-29 ml/min: 10 mg PO Q 72h Hemodialysis: 10 mg PO Q 7 days following hemodialysis	10 mg daily

VI. Product Availability

Drug	Availability
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CLINICAL POLICY

Hepatitis B Drugs

Entecavir (Baraclude)	Tablets: 0.5 mg, 1 mg Oral solution: 0.05 mg/ml
Adefovir dipivoxil (Hepsera)	Tablets: 10 mg

VII. References

1. Baraclude [Prescribing Information] Princeton, NJ: Bristol-Myers Squibb Company, August 2015.
2. Hepsera [Prescribing Information] Foster City, CA: Gilead Sciences; January 2012.
3. Epivir HBV [Prescribing Information] Research Triangle Park, NC: GlaxoSmithKline; May 2017.
4. Pegasys [Prescribing Information] South San Francisco, CA: Genentec; July 2013.
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CLINICAL POLICY

Hepatitis B Drugs

16. Lai CL, Rosmawati M, Lao J, et al. Entecavir is superior to lamivudine in reducing hepatitis B virus DNA in patients with chronic hepatitis B infection. *Gastroenterology*. 2002;123:1831-1838.
17. Clinical Pharmacology [database online]. Tampa FL: Gold Standard, Inc.; 2016. Available at <http://www.clinicalpharmacology-ip.com>. Accessed June 14, 2017.
18. American Hospital Formulary Service Drug Information. Available at <http://www.medicinescomplete.co/mc/ahfs/current/>. Accessed July 5, 2016.
19. Micromedex[®] Healthcare Series [Internet database]. Greenwood Village, CO: Thomson Healthcare. Updated periodically. Accessed June 14, 2017.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Converted to new template Annual Review: <ul style="list-style-type: none"> - Simplified medical necessity criteria to require only diagnosis of Hepatitis B and prescription by an appropriate specialist. - Tyzeka discontinued 2016. Supply generally exhausted by December 2016. Removed Tyzeka from criteria. 	06.14.17	11.17
Annual Review: No significant changes	08.29.18	

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.

CLINICAL POLICY

Hepatitis B Drugs

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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