

PHARMACY POLICY STATEMENT

BILLING CODE BENEFIT TYPE	Must use valid NDC
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For _____ authorization:

1. Member is 5 years of age or older; AND
2. Medication must be prescribed by, or in consultation with, a board certified hepatologist, gastroenterologist, infectious disease specialist; AND
3. Member has a diagnosis of Chronic Hepatitis C (CHC) with compensated liver disease; AND
4. Member will use in combination with other hepatitis C virus drugs; **Note:** Monotherapy is permitted for adults only if the patient has a contraindication to other hepatitis C drugs; AND
5. Member does _____ have any of the following;
 - a) Acute autoimmune hepatitis;
 - b) HIV;
 - c) Liver transplant;
 - d) Hepatic decompensation; AND
6.

Adults: 180 mcg (1.0 mL) subcutaneously once weekly.

Pediatrics: BSA x 180 mcg/1.732 m² subcutaneously once weekly.

Quantity Limit: 4 per 28 days

If all the above requirements are met, the medication will be approved for 48 weeks.

For _____:

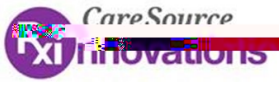
1. Chart notes must show improvement or stabilized signs and symptoms of disease, as demonstrated by an undetectable viral load.

If all the above requirements are met, the medication will be approved for an additional 12 months.

	<p>New policy for Pegasys created. Coverage for adults for Hepatitis C was removed since no longer recommended by AASLD guidelines and since other more effective treatments are currently available. NCCN recommendations of off-label use added. CHB criteria revised.</p>
	<p>Transferred to new template. Updated References.</p> <p><u>Hepatitis B:</u> Removed physician assistant or nurse practitioner and replaced with “in consultation with”; Clarified reauthorization criteria. Initial approval duration shortened to 48 weeks. Updated the ALT upper limit of normal per AASLD guidelines. Removed HIV exclusion from Hepatitis B indication.</p> <p><u>Hepatitis C:</u> Added adult indication to hepatitis C per package insert. Added Pegasys is supposed to be used in combination with other Hepatitis C drugs. Clarified reauthorization criteria. Added exclusion criteria.</p> <p>Removed off-label Myeloproliferative Neoplasms indication</p>

References:

1. Pegasys [package insert]. South San Francisco, CA: Genentech USA, Inc.; March 2021.
2. Update on Prevention, Diagnosis, and Treatment of Chronic Hepatitis B: AASLD 2018 Hepatitis B Guidance. PRACTICE GUIDANCE | HEPATOLOGY, VOL. 67, NO. 4, 2018.
3. AASLD/IDSA HCV guidance panel. Recommendations for testing, managing, and treating hepatitis C. Published: August 2020.



Effective date: 01/01/2023
Revised date: 06/21/2022