UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 1146-14
Program	Prior Authorization/Notification
Medication	Harvoni® (ledipasvir/sofosbuvir)
P&T Approval Date	10/2014, 2/2015, 8/2015, 11/2015, 12/2016, 12/2017, 12/2018, 2/2019, 2/2020, 2/2021, 2/2022, 2/2023, 2/2024
Effective Date	5/1/2024

1. Background:

Harvoni® (ledipasvir/sofosbuvir) is a fixed-dose combination of ledipasvir, a hepatitis C virus (HCV) NS5A inhibitor, and sofosbuvir, an HCV nucleotide analog NS5B polymerase inhibitor, and is indicated for the treatment of chronic hepatitis C virus (HCV) in adults and pediatric patients 3 years of age or older.

- Genotype 1, 4, 5, or 6 infection without cirrhosis or with compensated cirrhosis
- Genotype 1 infection with decompensated cirrhosis, in combination with ribavirin
- Genotype 1 or 4 infection who are liver transplant recipients without cirrhosis or with compensated cirrhosis, in combination with ribavirin.

2. Coverage Criteria[a]:

A. Chronic Hepatitis C - Genotype 1 - <u>Treatment-Naïve Patients without Cirrhosis and have a pre-treatment HCV RNA less than 6 million IU/mL:</u>

1. **Harvoni** will be approved based on **<u>all</u>** of the following criteria:

   a. Diagnosis of chronic hepatitis C genotype 1 infection

   -AND-

   b. Patient has a pre-treatment HCV RNA less than 6 million IU/mL

   -AND-

   c. Patient is without cirrhosis.

   -AND-

   d. Patient is treatment naïve [patient has not experienced treatment failure (defined as viral relapse, breakthrough while on therapy, or non-responder to therapy) with peginterferon +/- ribavirin based regimen with or without an HCV protease inhibitor (e.g., Incivek, Olysio, Victrelis) or Sovaldi (sofosbuvir)]

   -AND-

   e. Patient is not receiving Harvoni in combination with another HCV direct acting

antiviral agent [e.g., Sovaldi (sofosbuvir)]

Authorization will be issued for 8 weeks.

B. Chronic Hepatitis C - Genotype 1 - <u>Treatment-Naïve Patients without Cirrhosis and have a pre-treatment HCV RNA equal to or greater than 6 million IU/mL:</u>

1. **Harvoni** will be approved based on **<u>all</u>** of the following criteria:

   a. Diagnosis of chronic hepatitis C genotype 1 infection

   -AND-

   b. Patient has a pre-treatment HCV RNA equal to or greater than 6 million IU/mL

   -AND-

   c. Patient is without cirrhosis.

   -AND-

   d. Patient is treatment naïve [patient has not experienced treatment failure (defined as viral relapse, breakthrough while on therapy, or non-responder to therapy) with peginterferon +/- ribavirin based regimen with or without an HCV protease inhibitor (e.g., Incivek, Olysio, Victrelis) or Sovaldi (sofosbuvir)]

   -AND-

   e. Patient is not receiving Harvoni in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir)]

Authorization will be issued for 12 weeks.

C. Chronic Hepatitis C - Genotype 1 - <u>Treatment-Naïve Patients with Compensated Cirrhosis:</u>

1. **Harvoni** will be approved based on **<u>all</u>** of the following criteria:

   a. Diagnosis of chronic hepatitis C genotype 1 infection

   -AND-

   b. Patient has compensated cirrhosis (e.g., Child-Pugh A)

   -AND-

   c. Patient is treatment naïve [patient has not experienced treatment failure (defined as viral relapse, breakthrough while on therapy, or non-responder to therapy) with

peginterferon +/- ribavirin based regimen with or without an HCV protease inhibitor (e.g., Incivek, Olysio, Victrelis) or Sovaldi (sofosbuvir)]

-AND-

d. Patient is not receiving Harvoni in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir)]

Authorization will be issued for 12 weeks.

D. Chronic Hepatitis C - Genotype 1 - <u>Treatment-Experienced Patients without Cirrhosis:</u>

1. **Harvoni** will be approved based on **<u>all</u>** of the following criteria:

   a. Diagnosis of chronic hepatitis C genotype 1 infection

   -AND-

   b. Patient has experienced failure with a previous treatment regimen of a peginterferon alfa +/- ribavirin based regimen with or without an HCV protease inhibitor (e.g., Incivek, Olysio, Victrelis) or Sovaldi (sofosbuvir)

   -AND-

   c. Patient is without cirrhosis

   -AND-

   d. Patient is not receiving Harvoni in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir)]

Authorization will be issued for 12 weeks.

E. Chronic Hepatitis C - Genotype 1 - <u>Treatment-Experienced Patients with Compensated Cirrhosis:</u>

1. **Harvoni** will be approved based on **<u>all</u>** of the following criteria:

   a. Diagnosis of chronic hepatitis C genotype 1 infection

   -AND-

   b. Patient has experienced failure with a previous treatment regimen that included either peginterferon alfa +/- ribavirin based regimen with or without an HCV protease inhibitor (e.g., Incivek, Olysio, Victrelis) or Sovaldi (sofosbuvir)

-AND-

c. Patient has compensated cirrhosis (e.g., Child-Pugh A)

-AND-

d. Patient is without decompensated liver disease (e.g., Child-Pugh B or C)

-AND-

e. **One** of the following:

(1) Patient will receive Harvoni in combination with ribavirin

-OR-

(2) Patient is not eligible for ribavirin

-AND-

f. Patient is not receiving Harvoni in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir)]

In combination with ribavirin: Authorization will be issued for 12 weeks.

Ineligible for ribavirin: Authorization will be issued for 24 weeks.

F. Chronic Hepatitis C - Genotype 1 - Treatment-Naïve or Treatment-Experienced Patients with Decompensated Cirrhosis:

1. **Harvoni** will be approved based on **all** of the following criteria:

a. Diagnosis of chronic hepatitis C genotype 1 infection

-AND-

b. Patient has decompensated liver disease (e.g., Child-Pugh B or C)

-AND-

c. Patient will receive Harvoni in combination with ribavirin

-AND-

d. Patient is not receiving Harvoni in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir)]

Authorization will be issued for 12 weeks.

G. Chronic Hepatitis C - Genotype 4, 5 or 6 - <u>Treatment-Naïve or Treatment-Experienced Patients without Cirrhosis or with Compensated Cirrhosis:</u>

1. **Harvoni** will be approved based on **<u>all</u>** of the following criteria:

   a. Diagnosis of chronic hepatitis C genotype 4, 5 or 6 infection

   -AND-

   b. **<u>One</u>** of the following:

      (1) Patient is without cirrhosis

      -OR-

      (2) **<u>Both</u>** of the following:

         (a) Patient has compensated cirrhosis (e.g., Child-Pugh A)

         -AND-

         (b) Patient is without decompensated liver disease (e.g., Child-Pugh B or C)

   -AND-

   c. Patient is not receiving Harvoni in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir)]

   Authorization will be issued for 12 weeks.

H. Chronic Hepatitis C - Genotype 1 or 4 - Treatment-Naïve or Treatment-Experienced <u>Liver Transplant Recipients without Cirrhosis or with Compensated Cirrhosis:</u>

1. **Harvoni** will be approved based on **<u>all</u>** of the following criteria:

   a. Diagnosis of chronic hepatitis C genotype 1 or 4 infection

   -AND-

   b. Patient has previously received a liver transplant

   -AND-

   c. **<u>One</u>** of the following:

(1) Patient is without cirrhosis

-OR-

(2) **Both** of the following:

(a) Patient has compensated cirrhosis (e.g., Child-Pugh A)

-AND-

(b) Patient is without decompensated liver disease (e.g., Child-Pugh B or C)

-AND-

d. Patient is not receiving Harvoni in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir)]

-AND-

e. Patient will receive Harvoni in combination with ribavirin

Authorization will be issued for 12 weeks.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.
- Medical necessity may be in place.

4. References:

1. Harvoni [package insert]. Foster City, CA: Gilead Sciences, Inc.; March 2020.
2. American Association for the Study of Liver Diseases and the Infectious Diseases Society of America. Recommendations for Testing, Managing, and Treating Hepatitis C. http://www.hcvguidelines.org/full-report-view. Accessed December 21, 2023.

Program	Prior Authorization/Notification - Harvoni™ (ledipasvir/sofosbuvir)
Change Control	
10/2014	New program.
10/2014	Separated criteria sections to address treatment-naïve patients without cirrhosis and pre-treatment HCV RNA equal to or greater than 6 million IU/mL from the treatment-naïve patients with cirrhosis separately.

2/2015	Added Sovaldi as part of prior treatment criterion. Added criterion to prevent combination therapy.
8/2015	Added criteria for genotype 4 infection.
11/2015	Added genotype 5 and 6 based updated FDA approval.
12/2016	Added criteria for genotype 1 patients with decompensated cirrhosis. Updated genotype 1 treatment experienced criteria to include compensated cirrhosis only. Added criteria for post liver transplant genotype 1 or 4 patients per updated FDA label. Updated references.
12/2017	Annual review with no change to clinical coverage criteria. Updated references.
12/2018	Annual review with no change to clinical coverage criteria. Updated references.
2/2019	Updated references and removed Olysio from examples.
2/2020	Annual review. Added additional background information. Updated genotype 1 treatment-naïve criteria to include compensated cirrhosis only. Updated genotype 1 treatment experienced criteria treatment regimen and duration. Updated references.
2/2021	Annual review. Removed Olysio from list of examples for HCV direct acting antiviral agent with no change to clinical intent. Updated references
2/2022	Annual review with no changes to coverage criteria. Updated references.
2/2023	Annual review. Revised coverage criteria for Genotype 1 treatment-experienced patients with compensated cirrhosis per FDA label. Added state mandate and updated references.
2/2024	Annual review. Added cirrhosis criteria for treatment of chronic hepatitis C - genotype 4, 5 or 6.