I. Medication Description

Zepatier is a fixed-dose combination of elbasvir and grazoprevir which are direct-acting antiviral agents against the hepatitis C virus. Zepatier combines two direct-acting antiviral agents with distinct mechanisms of action and nonoverlapping resistance profiles to target HCV at multiple steps in the viral lifecycle. Elbasvir is an inhibitor of HCV NS5A, which is essential for viral RNA replication and virion assembly. The mechanism of action of elbasvir has been characterized based on cell culture antiviral activity and drug resistance mapping studies. Grazoprevir is an inhibitor of the HCV NS3/4A protease which is necessary for the proteolytic cleavage of the HCV encoded polyprotein (into mature forms of the NS3, NS4A, NS4B, NS5A, and NS5B proteins) and is essential for viral replication. In a biochemical assay, grazoprevir inhibited the proteolytic activity of the recombinant HCV genotype 1a, 1b, and 4a NS3/4A protease enzymes with IC50 values of 7 pM, 4 pM, and 62 pM, respectively.

II. Position Statement

Coverage is determined through a prior authorization process with supporting clinical documentation for every request.

III. Policy

Coverage of Zepatier can be granted if the following criteria are met:

- The member is at least 18 years of age AND
- Medication is prescribed by a:
  - hepatologist, gastroenterologist, infectious disease specialist, transplant physician, healthcare practitioner under the direct supervision of one of the preceding listed specialists, or a healthcare practitioner experienced and trained in the treatment of HCV infection prescriber working in collaboration with one of these specialists, or a prescriber who has clinical experience with the management and treatment of HCV infection (defined as the management AND treatment of at least 10 patients with HCV infection within the past 12 months and at least 10 HCV-related CME credits in the last 12 months) OR
  - healthcare professional in partnership (defined as consultation, preceptorship, or via telemedicine) with an experienced HCV provider who meets the above criteria AND
- A diagnosis of chronic hepatitis C has been established and baseline viral load reported AND
  - Genotype and subgenotype is confirmed and documented AND
• When requesting coverage of a brand medication for which an A/B rated generic is available, there is sufficient evidence that the use of the A/B rated generic equivalent has resulted in inadequate results AND

• The member must have a documented contraindication to the use of a plan-preferred medication (Harvoni, Epclusa, Mavyret) that does not apply to the requested medication OR when at least ONE of the following criteria have been met:
  o The plan-preferred medications are contraindicated or will likely cause an adverse reaction by or physical or mental harm to the member.
  o The plan-preferred medications are expected to be ineffective based on the known clinical history and conditions of the member and the member’s prescription drug regimen.
  o The member has tried the plan-preferred medications or another prescription drug in the same pharmacologic class or with the same mechanism of action and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
  o The member is stable on the medication selected by their healthcare professional for the medical condition under consideration (where “stable” is defined as receiving the medication for an adequate period of time, have achieved optimal response, and continued favorable outcomes are expected UNLESS the medication was initially selected solely due to the availability of a drug sample or a coupon card and the member does not otherwise meet the definition of “stable”).
  o The plan-preferred medication is not in the best interest of the member because it will likely cause a significant barrier to the member’s adherence or to compliance with the member’s plan of care, will likely worsen a comorbid condition of the member, or will likely decrease the member’s ability to achieve or maintain reasonable functional ability in performing daily activities AND

• Usage (medication combination, dose and duration) is in accordance with current AASLD/IDSA treatment guidelines for chronic hepatitis C (http://www.hcvguidelines.org)

IV. Quantity Limitations

Up to 28 tablets per each 28 days will be covered.

V. Coverage Duration

Coverage duration will be determined in accordance with medication prescribing information and recommendations from current AASLD/IDSA treatment guidelines for chronic hepatitis C (http://www.hcvguidelines.org).

VI. Coverage Renewal Criteria

n/a

VII. Billing/Coding Information
Zepatier is available in cartons containing two 14-count child-resistant dose packs for a total of 28 tablets.

VIII. Summary of Policy Changes

• 4/22/16: new policy
• 9/15/16: no policy changes
• 5/1/17: step therapy criteria added
• 10/19/17: Epclusa and Mavyret added to criteria as preferred alternatives
• 11/1/18: no policy changes

IX. References


The Plan fully expects that only appropriate and medically necessary services will be rendered. The Plan reserves the right to conduct pre-payment and post-payment reviews to assess the medical appropriateness of the above-referenced therapies.

The preceding policy applies only to members for whom the above named pharmacy benefit medications are included on their covered formulary. Members with closed formulary benefits are subject to trying all appropriate formulary alternatives before a coverage exception for a non-formulary medication will be considered.

The preceding policy is a guideline to allow for coverage of the pertinent medication/product, and is not meant to serve as a clinical practice guideline.