Hepatitis B Antivirals

Goal(s):

- Approve treatment supported by medical evidence and consensus guidelines
- Cover preferred products when feasible for covered diagnosis

Length of Authorization:

- Up to 12 months; quantity limited to a 30-day supply per dispensing.

Requires PA:

- All Hepatitis B antivirals

Covered Alternatives:

- Preferred alternatives listed at http://www.orpdl.org/drugs/

Pediatric Age Restrictions:

- lamivudine (Epivir HBV) – 2-17 years
- adefovir dipivoxil (Hepsera) – 12 years and up
- entecavir (Baraclude) – 2 years and up
- telbivudine (Tyzeka) –16 years and up
- tenofovir disoproxil fumarate (Viread) – 12 years and up
- tenofovir alafenamide (Vemlidy) – safety and effectiveness not established in pediatrics

Approval Criteria		
1. What diagnosis is being treated?	Record ICD10 code	
2. Is the diagnosis an OHP-funded diagnosis?	**Yes:** Go to #3	**No:** Pass to RPh. Deny; not funded by the OHP
3. Is the request for an antiviral for the treatment of HIV/AIDS?	**Yes:** Approve for up to 12 months	**No:** Go to #4
4. Is the request for treatment of chronic Hepatitis B?	**Yes:** Go to #5	**No:** Pass to RPh. Deny; medical appropriateness

Approval Criteria		
5. Is this a continuation of current therapy previously approved by the FFS program (i.e. filled prescription within prior 90 days)? Verify via pharmacy claims. ***If request is for Pegasys, refer to PA criteria "Pegylated Interferon and Ribavirin."***	**Yes:** Go to Renewal Criteria	**No:** Go to #6
6. Has the client tried and is intolerant to, resistant to, or has a contraindication to the preferred products?	**Yes:** Document intolerance or contraindication. Approve requested treatment for 6 months with monthly quantity limit of 30-day supply.	**No:** Go to #7
7. Will the prescriber consider a change to a preferred product?	**Yes:** Inform prescriber of covered alternatives in class	**No:** Approve requested treatment for 6 months with monthly quantity limit of 30-day supply
Renewal Criteria		
1. Is the patient adherent with the requested treatment (see refill history)?	**Yes:** Go to #2	No: Deny; Pass to RPh for provider consult
2. Is HBV DNA undetectable (below 10 IU/mL by real time PCR) or the patient has evidence of cirrhosis? Note: Antiviral treatment is indicated irrespective of HBV DNA level in patients with cirrhosis to prevent reactivation.	**Yes:** Approve for up to 1 year with monthly quantity limit of 30-day supply	No: Deny; pass to RPh for provider consult

P&T Review: *3/17(MH); 3/12*
Implementation: *4/1/17; 5/29/14; 1/13*