

Clinical Policy: Sofosbuvir (Sovaldi)

Reference Number: NH.PHAR.281

Effective Date: 09.19

Last Review Date: 06.23

Line of Business: Medicaid

[Revision Log](#)

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

Description

Sofosbuvir (Sovaldi®) is hepatitis C virus (HCV) nucleotide analog NS5B polymerase inhibitor.

FDA Approved Indication(s)

Sovaldi is indicated for the treatment of chronic HCV infection in:

- Adult patients without cirrhosis or with compensated cirrhosis:
 - Genotype 1 or 4 for use in combination with pegylated interferon and ribavirin (RBV).
 - Genotype 2 or 3 for use in combination with RBV.
- Pediatric patients 3 years of age and older with genotype 2 or 3 without cirrhosis or with compensated cirrhosis in combination with RBV.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

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

I. Initial Approval Criteria

A. Chronic Hepatitis C Infection (must meet all):

1. Diagnosis of chronic HCV infection as evidenced by detectable serum HCV RNA levels by quantitative assay in the last 6 months;
2. Confirmed HCV genotype is one of the following (a or b):
 - a. For adults (age ≥ 18 years): Genotypes 1, 2, 3, 4, 5, or 6;
 - b. For pediatrics (age ≥ 3 years): Genotypes 2 or 3;**Chart note documentation and copies of lab results are required*
3. Documentation of treatment status of the member (treatment-naïve or treatment-experienced);
4. Documentation of cirrhosis status of the member (no cirrhosis, compensated cirrhosis, or decompensated cirrhosis);
6. Member must use **Mavyret®**, **ledipasvir-sofosbuvir (authorized generic for Harvoni®)** or **sofosbuvir/velpatasvir (authorized generic for Epclusa®)** unless clinically significant adverse effects are experienced or both are contraindicated; **Coadministration with omeprazole up to 20 mg is not considered acceptable medical justification for inability to use Epclusa*
7. For pediatric patients (age ≥ 3 years) with genotype 2 or 3: Use is in combination with RBV;

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8. Life expectancy \geq 12 months with HCV treatment;
9. Prescribed regimen is consistent with an FDA or AASLD-IDSA recommended regimen (*see Section V Dosage and Administration for reference*);
10. Dose does not exceed 400 mg per day.

Approval duration: up to a total of 24 weeks*

(*Approved duration should be consistent with a regimen in Section V Dosage and Administration)

B. Other diagnoses/indications (must meet all):

1. Member must use sofosbuvir/velpatasvir (authorized generic for Epclusa), ledipasvir-sofosbuvir (authorized generic for Harvoni) or Mavyret if applicable for the requested indication, unless clinically significant adverse effects are experienced or both are contraindicated;*

**Coadministration with omeprazole up to 20 mg is not considered acceptable medical justification for inability to use Epclusa*

2. One of the following (a or b):
 - a. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (i or ii):
 - i. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
 - ii. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
 - b. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 2a above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Chronic Hepatitis C Infection (must meet all):

1. Member meets one of the following (a, b, or c):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
 - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
 - c. Must meet both of the following (i and ii):
 - i. Documentation supports that member is currently receiving Sovaldi for chronic HCV infection and has recently completed at least 60 days of treatment with Sovaldi;
 - ii. Confirmed HCV genotype is one of the following (1 or 2):
 - a. For adults (age \geq 18 years): Genotypes 1, 2, 3, 4, 5, or 6;
 - b. For pediatrics (age \geq 3 years): Genotypes 2 or 3;
2. Member is responding positively to therapy;
3. Dose does not exceed 400 mg per day.

Approval duration: up to a total of 24 weeks*

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(*Approved duration should be consistent with a regimen in Section V Dosage and Administration)

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

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 policies – CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AASLD: American Association for the Study of Liver Diseases

FDA: Food and Drug Administration

HBV: hepatitis B virus

HCV: hepatitis C virus

HIV: human immunodeficiency virus

IDSA: Infectious Diseases Society of America

NS3/4A, NS5A/B: nonstructural protein

PegIFN: pegylated interferon

RBV: ribavirin

RNA: ribonucleic acid

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
sofosbuvir/ velpatasvir (Epclusa®)	Without cirrhosis or with compensated cirrhosis, treatment naïve or treatment experienced*: Genotypes 1 through 6 One tablet PO QD for 12 weeks	Adult/Peds ≥ 30 kg: sofosbuvir 400 mg /velpatasvir 100 mg (one tablet) per day; Peds 17 to < 30 kg: sofosbuvir 200 mg /velpatasvir 50 mg per day;

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Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
		Peds < 17 kg: sofosbuvir 150 mg /velpatasvir 37.5 mg per day
Mavyret® (glecaprevir /pibrentasvir)	Treatment-naïve: Genotypes 1 through 6 Without cirrhosis or with compensated cirrhosis: 3 tablets PO QD for 8 weeks	Adults/Peds age ≥ 12 years or with body weight ≥ 45 kg: glecaprevir 300 mg/pibrentasvir 120 mg (3 tablets) per day;
Mavyret® (glecaprevir /pibrentasvir)	Treatment-experienced with IFN/pegIFN, RBV and/or sofosbuvir: Genotypes 1, 2, 4, 5, or 6 Without cirrhosis: 3 tablets PO QD for 8 weeks With compensated cirrhosis: 3 tablets PO QD for 12 weeks	Peds age 3 years to < 12 years of age with body weight < 20 kg: glecaprevir 150 mg/pibrentasvir 60 mg per day;
Mavyret® (glecaprevir /pibrentasvir)	Treatment-experienced with IFN/pegIFN, RBV and/or sofosbuvir: Genotype 3 Without cirrhosis or with compensated cirrhosis: 3 tablets PO QD for 16 weeks	Peds age 3 years to < 12 years of age with body weight 20 kg to < 30 kg: glecaprevir 200 mg/pibrentasvir 80 mg per day; Peds age 3 years to < 12 years of age with body weight 30 kg to < 45 kg: glecaprevir 250 mg/pibrentasvir 100 mg per day

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.

*Treatment-experienced refers to previous treatment with NS3/4A protease inhibitor (telaprevir, boceprevir, or simeprevir) and/or peginterferon/RBV unless otherwise stated.

‡ Off-label, AASLD-IDSA guideline-supported dosing regimen

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): when used in combination with peginterferon alfa/RBV or RBV alone, all contraindications to peginterferon alfa and/or RBV also apply to Sovaldi combination therapy.
- Boxed warning(s): risk of hepatitis B virus (HBV) reactivation in patients coinfecting with HCV and HBV.

Appendix D: Direct-Acting Antivirals for Treatment of HCV Infection

Brand Name	Drug Class				
	NS5A Inhibitor	Nucleotide Analog NS5B Polymerase Inhibitor	Non-Nucleoside NS5B Polymerase Inhibitor	NS3/4A Protease Inhibitor (PI)	CYP3A Inhibitor
Epclusa*	Velpatasvir	Sofosbuvir			
Harvoni*	Ledipasvir	Sofosbuvir			
Mavyret*	Pibrentasvir			Glecaprevir	
Sovaldi		Sofosbuvir			
Viekira Pak*	Ombitasvir		Dasabuvir	Paritaprevir	Ritonavir
Vosevi*	Velpatasvir	Sofosbuvir		Voxilaprevir	
Zepatier*	Elbasvir			Grazoprevir	

*Combination drugs

Appendix E: General Information

- Acceptable medical justification for inability to use Mavyret (preferred product):
 - Moderate or severe hepatic impairment (Child-Pugh B or C) or those with any history of prior hepatic decompensation: use of Mavyret is not recommended as postmarketing cases of hepatic decompensation/failure have been reported in these patients.
 - Drug-drug interactions with the following agents:
 - Atazanavir
 - Efavirenz
- Unacceptable medical justification for inability to use Epclusa (preferred product):
 - Coadministration with omeprazole up to 20 mg is not considered acceptable medical justification for inability to use Epclusa.
 - Per the Epclusa Prescribing Information: “If it is considered medically necessary to coadminister, Epclusa should be administered with food and taken 4 hours before omeprazole 20 mg.”
- HBV reactivation is a Black Box Warning for all direct-acting antiviral drugs for the treatment of HCV. HBV reactivation has been reported when treating HCV for patients co-infected with HBV, leading to fulminant hepatitis, hepatic failure, and death, in some cases. Patients should be monitored for HBV reactivation and hepatitis flare during HCV treatment and post-treatment follow-up, with treatment of HBV infection as clinically indicated.

- Child-Pugh Score:

	1 Point	2 Points	3 Points
Bilirubin	Less than 2 mg/dL Less than 34 umol/L	2-3 mg/dL 34-50 umol/L	Over 3 mg/dL Over 50 umol/L
Albumin	Over 3.5 g/dL Over 35 g/L	2.8-3.5 g/dL 28-35 g/L	Less than 2.8 g/dL Less than 28 g/L

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	1 Point	2 Points	3 Points
INR	Less than 1.7	1.7 - 2.2	Over 2.2
Ascites	None	Mild / medically	Moderate-severe / poorly controlled
Encephalopathy	None	Mild / medically controlled	Moderate-severe / poorly controlled. Grade III-IV

Child-Pugh class is determined by the total number of points: A = 5-6 points; B = 7-9 points; C = 10-15 points.

V. Dosage and Administration

Indication: Adult patients with chronic HCV infection			
Drugs	Dosing Regimen	Maximum Dose	Reference
Sovaldi + pegIFN + RBV	Genotype 1 or 4 Treatment-naïve without cirrhosis or with compensated cirrhosis: Sovaldi 400 mg + pegIFN + weight-based RBV for 12 weeks	Sovaldi 400 mg/day	FDA-approved labeling
Sovaldi + RBV	Genotype 2 Treatment-naïve and treatment-experienced*, without cirrhosis or with compensated cirrhosis: Sovaldi 400 mg + weight-based RBV for 12 weeks	Sovaldi 400 mg/day	FDA-approved labeling
Sovaldi + RBV	Genotype 3 Treatment-naïve and treatment-experienced*, without cirrhosis or with compensated cirrhosis: Sovaldi 400 mg + weight-based RBV for 24 weeks	Sovaldi 400 mg/day	FDA-approved labeling
Sovaldi + Mavyret + RBV	Genotypes 1 through 6 Patients with prior sofosbuvir/velpatasvir/voxilaprevir or glecaprevir/pibrentasvir treatment failure, with or without compensated cirrhosis:† Sovaldi 400 mg + Mavyret 300 mg/120 mg + weight-based RBV for 16 weeks	Sovaldi 400 mg/day	AASLD/IDSA (updated October 2022)

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AASLD/IDSA treatment guidelines for chronic hepatitis C infection are updated at irregular intervals; refer to the most updated AASLD/IDSA guideline for most accurate treatment regimen.

* Treatment-experienced refers to previous treatment with peginterferon with or without RBV unless otherwise stated.

† Off-label, AASLD-IDSA guideline-supported dosing regimen

Indication: Pediatric patients (age ≥ 3 years) with chronic HCV infection			
Drugs	Dosing Regimen	Maximum Dose	Reference
Sovaldi + RBV	Genotype 2 Treatment-naïve or treatment-experienced*, without cirrhosis or with compensated cirrhosis: <ul style="list-style-type: none"> • ≥ 35 kg: Sovaldi 400 mg + weight-based RBV for 12 weeks • 17 to < 35 kg: Sovaldi 200 mg + weight-based RBV for 12 weeks • < 17 kg: Sovaldi 150 mg + weight-based RBV for 12 weeks 	Sovaldi: 400 mg/day	FDA-approved labeling
Sovaldi + RBV	Genotype 3 Treatment-naïve or treatment-experienced*, without cirrhosis or with compensated cirrhosis: <ul style="list-style-type: none"> • ≥ 35 kg: Sovaldi 400 mg + weight-based RBV for 24 weeks • 17 to < 35 kg: Sovaldi 200 mg + weight-based RBV for 24 weeks • < 17 kg: Sovaldi 150 mg + weight-based RBV for 24 weeks 	Sovaldi: 400 mg/day	FDA-approved labeling

AASLD/IDSA treatment guidelines for chronic hepatitis C infection are updated at irregular intervals; refer to the most updated AASLD/IDSA guideline for most accurate treatment regimen.

*Treatment-experienced refers to previous treatment with peginterferon with or without RBV unless otherwise stated.

VI. Product Availability

- Tablets: 400 mg, 200 mg
- Oral pellets: 200 mg, 150 mg

VII. References

1. Sovaldi Prescribing Information. Foster City, CA: Gilead Sciences, Inc.; March 2020. Available at: <http://www.sovaldi.com/>. Accessed April 21, 2023.
2. American Association for the Study of Liver Diseases/ Infectious Disease Society of America (AASLD-IDSA). HCV guidance: recommendations for testing, managing, and

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treating hepatitis C. Last updated October 24, 2022. Available at:
<https://www.hcvguidelines.org/>. Accessed May 5, 2023.

3. CDC. Hepatitis C Q&As for health professionals. Last updated August 7, 2020. Available at:
<https://www.cdc.gov/hepatitis/hcv/hcvfaq.htm>. Accessed May 5, 2023.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy created.	06.19	07.19
Added “provider who has expertise in treating HCV based on a certified training program” to criteria for approval	11.19	01.20
Updated FDA Approved Indications section. Updated initial approval criteria age and duration of approvals. Updated duration of approval for continued therapy. Updated appendices, dosing charts, and references.	07.20	07.20
Updated appendices and references sections	07.21	07.21
3Q 2022 annual review: no significant changes; added omeprazole coadministration as unacceptable rationale for not using preferred Epclusa and removed redundant rationale in Appendix E references; reviewed and updated.	07.22	07.22
3Q 2023 annual review: removed prescriber specialty criterion per Medicaid plan requests; added previous Mavyret experience to initial approval criteria scenarios per AASLD recommended regimens; eliminated adherence program participation criterion due to competitor analysis; added redirections to other diagnoses initial criteria section; references reviewed and updated.	06.23	08.23

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,

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contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

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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