Pegasys (peginterferon alfa-2a)

BENEFIT APPLICATION

Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

DESCRIPTION

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

The criteria will require the use of the health plan’s preferred agents for chronic Hepatitis C therapy (Epclusa, Harvoni, Mavyret, and Vosevi) before the use of other non-preferred agents, unless there are clinical circumstances that exclude the preferred agents, or the patient is currently receiving treatment with a non-preferred agent.

FDA-Approved Indications

1. Chronic Hepatitis C
   Pegasys, as part of a combination regimen with other hepatitis C virus (HCV) antiviral drugs, is indicated for the treatment of adults with chronic hepatitis C (CHC) with compensated liver disease. Pegasys in combination with ribavirin is indicated for treatment of pediatric patients 5 years of age and older with CHC and compensated liver disease. Pegasys monotherapy is only indicated for the treatment of patients with CHC with compensated liver disease if there are contraindications or significant intolerance to other HCV antiviral drugs.

2. Chronic Hepatitis B
   Pegasys is indicated for the treatment of adult patients with HBeAg-positive and HBeAg-negative chronic hepatitis B infection who have compensated liver disease and evidence of viral replication and liver inflammation.

Compendial Uses

1. Myeloproliferative neoplasm (essential thrombocytethemia, polycythemia vera, primary myelofibrosis and post-polycythemia vera or post-essential thrombocytethemia myelofibrosis)

All other indications are considered experimental/investigational and are not a covered benefit.

POLICY

Required Documentation

The following information is necessary to initiate the prior authorization review:

- Presence of viral load (HCV RNA) in the serum prior to treatment with the requested regimen
• Genotype and subtype (if applicable)
• Baseline or current viral load
• Laboratory testing for resistance-associated variants (if applicable)
• METAVIR fibrosis score (if applicable)
• Liver transplantation status
• Treatment plan including treatment regimen and duration
• Prior treatment regimen(s) and response
• Prescriber specialty

Exclusions

• Decompensated cirrhosis (Child Turcotte Pugh Class B or C)

Note: When the requested drug is being used in a combination therapy regimen, exclusions to the other antiviral drugs also apply.

Initial Criteria for Approval

*The criteria will require the use of the health plan's preferred agents for chronic Hepatitis C therapy (Epclusa, Harvoni, Mavyret, and Vosevi) before the use of other non-preferred agents, unless there are clinical circumstances that exclude the preferred agents, or the patient is currently receiving treatment with a non-preferred agent.

A. **Chronic hepatitis C virus (HCV) infection**
   Refer to the drug policy of requested regimen for the specific criteria for approval and approval durations.

B. **Chronic hepatitis B virus (HBV) infection (including HDV coinfection)**
   Authorization of up to 48 weeks total may be granted for the treatment of chronic HBV infection, including HDV coinfection.

C. **Myeloproliferative neoplasm**
   Authorization of 12 months may be granted for the treatment of myeloproliferative neoplasm (essential thrombocytemia, polycythemia vera, primary myelofibrosis and post-polycythemia vera or post-essential thrombocytemia myelofibrosis).

Continuation of Therapy

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

Dosing and Administration

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Dosing Limits

• 180 mcg per week

Dispensing Limits

• A 28-day supply dispense limit applies to all targeted hepatitis C agents in order to better manage the therapy regimen.

**PROCEDURES AND BILLING CODES**

To report provider services, use appropriate CPT* codes, Alpha Numeric (HCPCS level 2) codes, Revenue codes, and/or ICD diagnostic codes.
REFERENCES


*Some content reprinted from CVSHealth

POLICY HISTORY

Policy #: 05.01.103  
Policy Creation: January 2016  
Reviewed: October 2018  
Revised: February 2018  
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