Pegylated Interferons and Ribavirins

Goal(s):

- Cover drugs only for those clients where there is medical evidence of effectiveness and safety

Length of Authorization:

16 weeks plus 12-36 additional weeks or 12 months

Requires PA:

- All drugs in HIC3 = W5G

Covered Alternatives:

- Current PMPDP preferred drug list per OAR 410-121-0030 at www.orpdl.org
- Searchable site for Oregon FFS Drug Class listed at www.orpdl.org/drugs/

Approval Criteria		
1. Is peginterferon requested preferred?	**Yes:** Go to #4	**No:** Go to #2
2. Will the prescriber consider a change to a preferred product? Message: Preferred products are evidence-based reviewed for comparative effectiveness & safety Oregon Pharmacy and Therapeutics (P&T) Committee	**Yes:** Inform provider of covered alternatives in class.	**No:** Go to #3
3. If the request is for interferon alfacon-1, does the patient have a documented trial of a pegylated interferon?	**Yes:** Go to #4	**No:** Pass to RPh. Deny; medical appropriateness
4. Is the request for treatment of Chronic Hepatitis C? Document appropriate ICD10 code: (K739; K730; K732 or K738)	**Yes:** Go to #5	**No:** Go to #11
5. Is the request for continuation of therapy previously approved by the FFS program? (Patient has been on HCV treatment in the preceding 12 weeks according to the Rx profile)	**Yes:** Go to "Continuation of Therapy"	**No:** Go to #6

Approval Criteria		
6. Does the patient have a history of treatment with previous pegylated interferon-ribavirin combination treatment? Verify by reviewing member's Rx profile for PEG-Intron or Pegasys, PLUS ribavirin history. Does not include prior treatment with interferon monotherapy or non-pegylated interferon.	**Yes:** Forward to DMAP Medical Director	**No:** Go to #7
7. Does the patient have any of the following contraindications to the use of interferon-ribavirin therapy? • severe or uncontrolled psychiatric disorder • decompensated cirrhosis or hepatic • encephalopathy • hemoglobinopathy • untreated hyperthyroidism • severe renal impairment or transplant • autoimmune disease • pregnancy • unstable CVD	**Yes:** Pass to RPh. Deny; medical appropriateness	**No:** Go to #8
8. If applicable, has the patient been abstinent from IV drug use or alcohol abuse for ≥ 6 months?	**Yes:** Go to #9	**No:** Pass to RPh. Deny; medical appropriateness
9. Does the patient have a detectable HCV RNA (viral load) > 50IU/mL? Record HCV RNA and date.	**Yes:** Go to #10	**No:** Pass to RPh. Deny; medical appropriateness

Approval Criteria		
10. Does the patient have a documented HCV Genotype? Record Genotype.	**Yes:** Approve for 16 weeks with the following response: Your request for has been approved for an initial 16 weeks. Subsequent approval is dependent on documentation of response via a repeat viral load demonstrating undetectable or 2-log reduction in HCV viral load. Please order a repeat viral load after 12 weeks submit lab results and relevant medical records with a new PA request for continuation therapy. Note: For ribavirin approve the generic only.	**No:** Pass to RPh. Deny; medical appropriateness
11. Is the request for Pegasys and the treatment for confirmed, compensated Chronic Hepatitis B?	**Yes:** Go to #11	**No:** Pass to RPh. Deny; medical appropriateness
12. Is the patient currently on LAMIVUDINE (EPIVIR HBV), ADEFOVIR (HEPSERA), ENTECAVIR (BARACLUDE), TELBIVUDINE (TYZEKA) and the request is for combination Pegasys-oral agent therapy?	**Yes:** Pass to RPh. Deny; medical appropriateness	**No:** Go to #12
13. Has the member received previous treatment with pegylated interferon?	**Yes:** Pass to RPh. Deny; medical appropriateness Recommend: LAMIVUDINE (EPIVIR HBV) ADEFOVIR (HEPSERA)	**No:** Approve Pegasys #4 x 1mL vials or #4 x 0.5 mL syringes per month for 12 months (maximum per lifetime).

<table>
<tr><th colspan="4">Continuation of Therapy- HCV</th></tr>
<tr>
<td>1. Does the client have undetectable HCV RNA or at least a 2-log reduction (+/- one standard deviation) in HCV RNA measured at 12 weeks?</td>
<td colspan="2">Yes: Approve as follows:

Approval for beyond quantity and duration limits requires approval from the medical director.

<table>
<tr><th>Geno-type</th><th>Approve for:</th><th>Apply</th></tr>
<tr><td>1 or 4</td><td>An additional 36 weeks or for up to a total of 48 weeks of therapy (whichever is the lesser of the two).</td><td>Ribavirin quantity limit of 200 mg tablets QS# 180 / 25 days (for max daily dose =1200 mg).</td></tr>
<tr><td>2 or 3</td><td>An additional 12 weeks or for up to a total of 24 weeks of therapy (whichever is the lesser of the two).</td><td>Ribavirin quantity limit of 200 mg tab QS# 120 / 25 days (for max daily dose = 800 mg).</td></tr>
<tr><td>For all genotypes and HIV co-infection</td><td>An additional 36 weeks or for up to a total of 48 weeks of therapy (whichever is the lesser of the two)</td><td>Ribavirin quantity limit of 200 mg tablets QS# 180 / 25 days (for max daily dose = 1200 mg).</td></tr>
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</td>
<td>No: Pass to RPh. Deny; medical appropriateness

Treatment with pegylated interferon-ribarvirin does not meet medical necessity criteria because there is poor chance of achieving an SVR.</td>
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</table>

Clinical Notes:

- Serum transaminases: Up to 40% of clients with chronic hepatitis C have normal serum alanine aminotransferase (ALT) levels, even when tested on multiple occasions.

- RNA: Most clients with chronic hepatitis C have levels of HCV RNA (viral load) between 100,000 (105) and 10,000,000 (107) copies per ml. Expressed as IU, these averages are 50,000 to 5 million IU. Rates of response to a course of peginterferon-ribavirin are higher in clients with low levels of HCV RNA. There are several definitions of a “low level” of HCV RNA, but the usual definition is below 800,000 IU (~ 2 million copies) per ml (5).

- Liver biopsy: Not necessary for diagnosis but helpful for grading the severity of disease and staging the degree of fibrosis and permanent architectural damage and for ruling out other causes of liver disease, such as alcoholic liver injury, nonalcoholic fatty liver disease, or iron overload.

Stage is indicative of fibrosis:			Grade is indicative of necrosis:	
Stage 0	No fibrosis			
Stage 1	Enlargement of the portal areas by fibrosis		Stage 1	None
Stage 2	Fibrosis extending out from the portal areas with rare bridges between portal areas		Stage 2	Mild
Stage 3	Fibrosis that link up portal and central areas of the liver		Stage 3	Moderate
Stage 4	Cirrhosis		Stage 4	Marked

The following are considered investigational and/or do not meet medical necessity criteria:

- Treatment of HBV or HCV in clinically decompensated cirrhosis
- Treatment of HCV or HBV in liver transplant recipients
- Treatment of HCV or HBV > 48 weeks
- Treatment of advanced renal cell carcinoma
- Treatment of thrombocytopenia
- Treatment of human papilloma virus
- Treatment of multiple myeloma

P&T Review: *2/12; 9/09; 9/05; 11/04; 5/04*
Implementation: *5/14/12, 1/1/10, 5/22/08*