Effective Date: 08/01/2021
Reviewed: 06/2021, 2/2022, 4/2022, 5/2023, 6/2024, 6/2025, 4/2026 Scope: Medicaid

Hepatitis C Criteria

Preferred, No Authorization:
Mavyret (glecaprevir and pibrentasvir)

Preferred, Authorization may be required
Vosevi (sofosbuvir, velpatasvir, and voxilaprevir) *

Non-Preferred, Authorization Required:
Epclusa (sofosbuvir and velpatasvir)
Harvoni (ledipasvir and sofosbuvir)
Sovaldi (sofosbuvir)
Zepatier (elbasvir and grazoprevir)

POLICY

I. CRITERIA FOR APPROVAL

*Vosevi will be covered with no authorization if there is at least one paid claim for an HCV agent within the last 365 days.

A. Prescribers must be enrolled as a billing provider or an ordering, prescribing or referring (OPR) provider with Rhode Island Medicaid.
B. Beneficiaries:
    i. All patients with documented Hepatitis C Stages 0 through 4 are eligible for treatment.
C. Required Documentation:
    i. Prior Authorization is not required when prescribing Mavyret.
    ii. Prior Authorization is not required for prescribing Vosevi when used as a salvage medication after prior treatment failure. See package insert for FDA approved indication, and prescribing information.
    iii. Neither Mavyret nor Vosevi require genotyping.
    iv. Treatment request for non-preferred medications require genotyping.
    v. History of prior Hepatitis C treatment if relevant.
    vi. Treatment plan which includes:
        i. Medication name, dose and duration.
        ii. Agreement to submit post treatment viral load data if requested.
D. Treatment recommendations as of August 1, 2021:
    i. Preferred agents: Mavyret and Vosevi.
    ii. Non preferred agents: all other agents with exception of ribavirin;
        i. Will be approved if patient is completing a cycle of therapy initiated prior to current policy implementation date, or

ii. Will be reviewed on a case-by-case basis. The Prior Authorization request must include clinical documentation of need for an alternative, non-preferred agent.

E. Continuity of Treatment:

i. When transitioning between publicly funded delivery systems (i.e., between Fee for Service Medicaid and Managed Care Medicaid, between Managed Care Medicaid and Fee for Service Medicaid or between the Department of Corrections and the Medicaid Program) any medication approval by the prior delivery system will be honored for the portion of the treatment that remains after the transition.

II. QUANTITY LIMIT

- Mavyret
  - 100-40mg tablet: 3 tablets per day
  - 50-20mg pak (oral pellets): 6 per day for ages 3-17
- Vosevi, Epclusa, Harvoni, Sovaldi, and Zepatier: 1 per day

III. COVERAGE DURATION

- The request will be authorized until the appropriate treatment duration is completed.

IV. REFERENCES

1. Mavyret [package insert]. North Chicago, IL: AbbVie Inc.; June 2025.
2. Vosevi [package insert]. Foster City, CA: Gilead Sciences, Inc.; July 2025
3. Epclusa [package insert]. Foster City, CA: Gilead Sciences, Inc.;June 2024
4. Harvoni [package insert]. Foster City, CA: Gilead Sciences, Inc.; December 2024
5. Sovaldi [package insert]. Foster City, CA: Gilead Sciences, Inc.; December 2024
6. Zepatier [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; July 2024