I. POLICY

It is the policy of UPMC Health Plan to maintain a prior authorization process that promotes appropriate utilization of specific drugs with potential for misuse or limited indications. This process involves a review using Food and Drug Administration (FDA) criteria to make a determination of Medical Necessity, as defined in CRM.015-Medical Necessity, and approval by the Pharmacy & Therapeutics Committee of the criteria for prior authorization, as described in RX.003-Prior Authorization Process.

The Chronic Hepatitis C drugs are subject to the prior authorization process.

II. DEFINITIONS

Non-responder – A member who does not respond to therapy (obtains no chronic elimination of HCV-RNA) with medications in this policy.

Relapser – A member who obtains an initial response to therapy (complete elimination of HCV-RNA) with medications in this policy, however upon discontinuation of the medications has a return elevation of HCV-RNA.

III. PURPOSE

The purpose of this policy is to define the Prior Authorization Process for Peginterferon®/Intron A®/Roferon A®/Infergen® for Chronic Hepatitis C.

IV. SCOPE

This policy applies to the Pharmacy services Department.
V.  PROCEDURE

interferon alfa-2b (Intron® A) is indicated for the treatment of hairy cell leukemia, malignant melanoma, follicular lymphoma, condylomata acuminata, AIDS-Related Kaposi’s Sarcoma, and chronic hepatitis C in members at least 18 years of age or older. It is indicated for the treatment of chronic hepatitis B in members 1 year of age or older.

interferon alfa-2a (Roferon® A) is indicated for the treatment of chronic hepatitis C and hairy cell leukemia in members at least 18 years of age or older. It is also indicated for chronic phase, Philadelphia chromosome positive chronic myelogenous leukemia (CML) members who are minimally pretreated (within 1 year of diagnosis).

interferon alfacon-1 (Infergen®) is indicated for the treatment of chronic hepatitis C in members at least 18 years of age or older with compensated liver disease.

peginterferon alfa-2b (PEG-Intron®) and peginterferon alfa-2a (Pegasys®) are indicated as either monotherapy or in combination with ribavirin for the treatment of chronic hepatitis C in members with compensated liver disease. Pegasys® is also indicated for the treatment of chronic hepatitis B in members with compensated liver disease.

The following precautions should be considered:

Alpha interferons may cause or aggravate fatal or life-threatening neuropsychiatric, autoimmune, ischemic, and infectious disorders. Members should be monitored closely and therapy should be withdrawn in members with persistently severe or worsening symptoms of these conditions.

Criteria for Peginterferons/Interferons for Chronic Hepatitis C

The following criteria must be met for approval of peginterferons/interferons:

1. For all members with chronic hepatitis C, peginterferon must be prescribed by an infectious disease physician, gastroenterologist, hepatologist, or a transplant physician or in consultation with these physicians.

2. The member must be at least 18 years of age.

3. The member must not have any of the following illnesses or conditions, which are contraindications for the use of peginterferons:
   - Autoimmune hepatitis or other conditions known to be exacerbated by interferon
   - Known hypersensitivity to drugs used to treat hepatitis C
   - Members with decompensated liver disease

4. Hepatitis C genotyping and a baseline quantitative hepatitis C virus titer (HCV RNA) must be obtained before starting therapy.
5. For the following conditions, treatment with peginterferons will be reviewed as follows:

Peginterferon plus ribavirin is considered the treatment of choice for adults with chronic hepatitis C. If a request for standard interferon is received for chronic hepatitis C treatment, the pegylated interferon will be authorized instead unless there is a reason why the member cannot take the pegylated products.

*For Initial Treatment of Chronic Hepatitis C Genotype 1*

For members with chronic hepatitis C genotype 1, treatment with peginterferon alfa is authorized for up to 16 weeks (the initial authorization is for 12 weeks with an additional 4 weeks granted for the prescriber to obtain the quantitative HCV RNA).

After 12 weeks of therapy, a quantitative HCV RNA is required to continue therapy. If the member has attained an early virologic response as defined by the achievement of at least a 100-fold (2 log 10) decrease in serum HCV RNA from pretreatment baseline and/or clearance of the HCV RNA, continued treatment for a maximum of 48 weeks is authorized.

If the member has not attained an early virologic response as indicated by the achievement of at least a 100-fold (2 log 10) decrease in serum HCV RNA from pretreatment baseline, further treatment with peginterferon is considered not medically necessary and should not be authorized. Consideration for continuation will be individualized based on severity of disease, demonstration of some virologic response, and tolerability of treatment.

*For Initial Treatment of Chronic Hepatitis C Genotypes 2 and 3*

For members with chronic hepatitis C genotypes 2 and 3 who have not been previously treated with interferon, treatment with peginterferon alfa is authorized for 24 weeks.

*For Treatment of Chronic Hepatitis C in HIV-Infected Members*

For all genotypes, treatment with peginterferon will be authorized for up to 48 weeks.

*For Treatment of Chronic Hepatitis C in Members with Renal Disease*

For all genotypes, treatment with peginterferon alfa-2A at a dose of 135mcg/week for members who are on hemodialysis will be authorized for up to 48 weeks.

*For Liver Transplant Members with Recurrent Hepatitis C*

For members with recurrent hepatitis C after liver transplantation, authorization will be evaluated on a case-by-case basis using the initial treatment criteria (including genotype and viral load) for up to 48 weeks.
Retreatment

Upon medical review, extended treatment with peginterferon alfa beyond the treatment course of 24-48 weeks may be considered medically necessary for persons with cryoglobulinemia. Furthermore, retreatment with peginterferon or consensus interferon at FDA approved dosing will be approved for nonresponders or relapsers who have significant fibrosis or cirrhosis and who have undergone previous regimens of treatment using pegylated and non-pegylated interferons. A liver biopsy will be required to determine the progression of disease for nonresponders and relapsers to initial therapy.

Extended or Maintenance Therapy

Requests for maintenance therapy will not be authorized. The risks and benefit of prescribing extended or maintenance therapy with peginterferons is under investigation, and currently being evaluated in ongoing clinical trials.

For Indications Other Than Hepatitis C

Authorization for treatment will be given for the following conditions:

For interferon alfa-2b (Intron® A):

- hairy cell leukemia
- malignant melanoma
- follicular lymphoma
- condylomata acuminata
- AIDS-Related Kaposi’s Sarcoma
- chronic hepatitis B (1 year of age or older)

For interferon alfa-2a (Roferon® A):

- hairy cell leukemia
- Philadelphia chromosome positive CML

For peginterferon alfa-2a (Pegasys®):

- chronic hepatitis B - adult (as monotherapy for 48 weeks)

Dosage of Peginterferons for Chronic Hepatitis C

The maximum approved dose of peginterferon alfa-2b (PEG-Intron®) is 1.5mcg/kg/week

The maximum approved dose of peginterferon alfa-2a (Pegasys®) is 180mcg/week
Dosage of Interferons for Chronic Hepatitis C

For interferon alfa-2b (Intron® A) the recommended dose is 3 million IU 3 times a week.

For interferon alfa-2a (Roferon® A) the recommended dose is 3 million IU 3 times a week. An alternative of 6 million IU 3 times a week for 3 months, followed by 3 million IU 3 times a week may be used.

For interferon alfacon-1 (Infergen®) the recommended dose is 9-15 mcg 3 times a week.

Limitations:
If the request does not meet the above approval criteria, the request will be referred to the UPMC Health Plan Medical Director for review.

VI. BIBLIOGRAPHY