Clinical Policy: Entecavir (Baraclude)

Reference Number: HIM.PA.08
Effective Date: 06.01.19
Last Review Date: 05.23
Line of Business: HIM

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Entecavir (Baraclude®) is a hepatitis B virus nucleoside analogue reverse transcriptase inhibitors.

FDA Approved Indication(s)

Baraclude is indicated for the treatment of chronic hepatitis B virus infection in adults and children at least 2 years of age with evidence of active viral replication and either evidence of persistent elevations in serum aminotransferases (ALT or AST) or histologically active disease.

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 Baraclude is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Hepatitis B Infection (must meet all)**:**

1. Diagnosis of hepatitis B virus infection;
2. Prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease specialist;
3. Age ≥ 2 years;
4. Evidence of active viral replication;
5. Member meets one of the following (a or b):
   a. Evidence of persistent elevations in serum aminotransferases (ALT or AST);
   b. Histologically active disease;
6. Member must meet either (a or b):
   a. For Baraclude tablet requests, member must use generic entecavir tablets, unless contraindicated or clinically significant adverse effects are experienced;
   b. For Baraclude oral solution requests: Documentation supports inability to swallow tablets;
7. Dose does not exceed either of the following (a or b):
   a. For oral tablet, both (i and ii):
      i. 1 mg per day;
      ii. 1 tablet per day;
   b. For oral solution: 20 mL per day (3 bottles per month).

Approval duration: 12 months

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: HIM.PA.33 for health insurance marketplace; 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: HIM.PA.103 for health insurance marketplace; 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: HIM.PA.154 for health insurance marketplace.

II. Continued Therapy

A. Hepatitis B Infection (must meet all)**:**
1. Member meets one of the following (a or b):
   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*;
2. Member is responding positively to therapy;
3. Member must meet either (a or b):
   a. For Baraclude tablet requests, member must use generic entecavir tablets, unless contraindicated or clinically significant adverse effects are experienced;
   b. For Baraclude oral solution requests: Documentation supports inability to swallow tablets;;
4. If request is for a dose increase, new dose does not exceed either one of the following (a or b):
   a. For oral tablets, both (i and ii):
      i. 1 mg per day;
      ii. 1 tablet per day;
   b. For oral solution: 20 mL per day (3 bottles per month).

Approval duration: 12 months

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: HIM.PA.33 for health insurance marketplace; 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: HIM.PA.103 for health insurance marketplace; 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: HIM.PA.154 for health insurance marketplace.

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 – HIM.PA.154 for health insurance marketplace or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AST: aspartate aminotransferase
ALT: alanine aminotransferase
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): none reported
- Boxed warning(s):
  - Severe acute exacerbation of hepatitis B
  - Potential for development of resistance to HIV nucleoside reverse transcriptase inhibitors
  - Lactic acidosis and hepatomegaly

V. Dosage and Administration

<table>
<tr><th>Indication</th><th>Dosing Regimen</th><th>Maximum Dose</th></tr>
<tr><td>Hepatitis B infection</td><td><u>Adults and adolescents ≥ 16 years</u>
Nucleoside inhibitor treatment-naïve: 0.5 mg PO QD

History of hepatitis B viremia while receiving lamivudine, known lamivudine/telbivudine resistance substitutions rtM204I/V, or decompensated liver disease: 1 mg PO QD

<u>Pediatric patients ≥ 2 years to < 16 years</u>
Weight-based dose PO QD:
<table>
<tr><th>Body weight (kg)</th><th>Treatment-Naïve</th><th>Lamivudine-Experienced</th></tr>
<tr><td>10 – 11</td><td>3 mL</td><td>6 mL</td></tr>
<tr><td>> 11 – 14</td><td>4 mL</td><td>8 mL</td></tr>
</table></td><td>1 mg/day or 20 mL/day</td></tr>
</table>

Indication	Dosing Regimen			Maximum Dose
	> 14 – 17	5 mL	10 mL	
	> 17 – 20	6 mL	12 mL	
	> 20 – 23	7 mL	14 mL	
	> 23 – 26	8 mL	16 mL	
	> 26 – 30	9 mL	18 mL	
	> 30	10 mL	20 mL	

VI. Product Availability

- Tablets: 0.5 mg, 1 mg
- Oral solution: 0.05 mg/mL

VII. References

1. Baraclude Prescribing Information. Princeton, NJ: Bristol-Myers Squibb Company; November 2019. Available at: www.baraclude.com. Accessed January 25, 2023.
2. Terrault NA, Lok ASF, McMahon BJ, et al. Update on prevention, diagnosis, and treatment of chronic hepatitis B: AASLD 2018 hepatitis B guidance. Hepatology. 2018; 67(4): 1560-1599.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created.	03.05.19	05.19
2Q 2020 annual review: no significant changes; corrected dosing from 18 mL/day to 20 mL/day per PI; updated Section V with pediatric weight-based dosing; references reviewed and updated.	01.24.20	05.20
2Q 2021 annual review: no significant changes; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	01.12.21	05.21
2Q 2022 annual review: no significant changes; added notation referring requests for brand Baraclude tablets to formulary exception policy per non-formulary status and availability of other formulary first-line HBV medications; for oral solution requests, added requirement to use the preferred formulary alternative (generic tablets); WCG-specific policy (WCG.HIM.PA.08) was retired and the approval duration was consolidated to 12 months for both Initial and Continued Therapy; references reviewed and updated.	02.02.22	05.22
Template changes applied to other diagnoses/indications and continued therapy section.	10.10.22	
2Q 2023 annual review: removed HIM pharmacy benefit non-formulary exception language as prior authorization for both brand and generic Baraclude tabs is required for several state HIM formularies; added entecavir oral tablet criteria with template	01.31.23	05.23

Reviews, Revisions, and Approvals	Date	P&T Approval Date
generic redirection verbiage; added maximum oral tablet dosing criteria; references reviewed and updated.		

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, 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.

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