Clinical Policy: Entecavir (Baraclude)

Reference Number: HIM.PA.08
Effective Date: 06.01.19
Last Review Date: 05.22
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. Only the oral solution requires prior authorization.

**For Health Insurance Marketplace (HIM),* *if request is through pharmacy benefit, brand Baraclude tablets are non-formulary and should not be approved using these criteria; refer to the formulary exception policy, HIM.PA.103. Please note generic entecavir tablets do not require prior authorization.*

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 use generic entecavir tablets, unless contraindicated to the excipients or documentation supports inability to swallow tablets;
7. Dose does not exceed 20 mL per day (3 bottles per month).

Approval duration: 12 months for Baraclude oral solution (*refer to HIM.PA.103 for brand Baraclude tablets*)

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PA.154 for health insurance marketplace.

II. Continued Therapy

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

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. Documentation supports continued inability to swallow tablets;
4. If request is for a dose increase, new dose does not exceed 20 mL per day (3 bottles per month).

Approval duration: 12 months for Baraclude oral solution (*refer to HIM.PA.103 for brand Baraclude tablets*)

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): 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>
<tr><td>> 14 – 17</td><td>5 mL</td><td>10 mL</td></tr>
<tr><td>> 17 – 20</td><td>6 mL</td><td>12 mL</td></tr>
<tr><td>> 20 – 23</td><td>7 mL</td><td>14 mL</td></tr>
<tr><td>> 23 – 26</td><td>8 mL</td><td>16 mL</td></tr>
<tr><td>> 26 – 30</td><td>9 mL</td><td>18 mL</td></tr>
<tr><td>> 30</td><td>10 mL</td><td>20 mL</td></tr>
</table></td><td>1 mg/day or 20 mL/day</td></tr>
</table>

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, 2022.
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

Reviews, Revisions, and Approvals	Date	P&T Approval Date
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

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.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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