

# HealthAlliance**MEDICARE**

## **PURPOSE OF THE POLICY**

To establish guidelines for coverage of medications in the treatment of Hepatitis B.

## **STATEMENT OF THE POLICY**

To define the criteria for coverage of lamivudine, Hepsera® (adefovovir dipivoxil), Tyzeka® (telbivudine), Pegasys® (peginterferon alfa-2a) for Hepatitis B treatment. Applies to new starts only for Medicare Part D members.

## **PROCEDURES**

### **1. General criteria for initial review of coverage**

- 1.1 Coverage requires the documentation of hepatitis B AND
- 1.2 ALT > 2 times upper normal limit

### **2. Exclusion criteria**

- 2.1 Hepsera
  - Children under age 12
- 2.2 Pegasys (peginterferon alfa-2a)
  - Contraindicated in decompensated liver disease

### **3. The recommended treatment duration for HBeAg-positive chronic hepatitis B is a minimum of 1 year.**

### **4. Reference:**

- 4.1 Lok A, McMahon B, Chronic Hepatitis B: Update of Recommendations, AASLD Practice Guidelines, Hepatology, March 2004
- 4.2 Lai C, Shouval D, Lok A, Entecavir versus Lamivudine for Patients with HBeAg-Negative Chronic Hepatitis B, The New England Journal of Medicine, 9 March 2006, v354:1011-1020