Pharmacy Drug Policy Checklist

POLICY NAME	Hepatitis B Treatment	POLICY #	936P

Criteria

Hepatitis B Coverage Criteria

☐ **1.1** Documentation of hepatitis B with one of the following:

- Without cirrhosis: ? HBeAg+, HBV >20,000IU/mL, ALT> 2x ULN OR ? HBeAg-, HBV >2000 IU/mL, and histological disease such as necroinflammation, significant fibrosis?
- With cirrhosis: ? HBV >2000 OR ? Decompensated disease?

Hepatitis B Prophylaxis Criteria

☐ **2.1** Documented HBV infection prophylaxis (preventative therapy) with liver transplant

Exclusion Criteria – Any of the following prevents coverage

☐ **3.1** Hepsera

☐ **3.4** Children under age 12 – Safety and efficacy have not been established for this population Pegasys (peginterferon alfa-2a)

- Contraindicated in decompensated liver disease
- Patients under 3 years old Vemlidy for patients under 6 years old or <25kg Baraclude for patients under 2 years old