

<b>POLICY NAME</b>	Hepatitis B Treatment	<b>POLICY #</b>	936P
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## Criteria

### Hepatitis B Coverage Criteria

- ☐ 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

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

### Exclusion Criteria – Any of the following prevents coverage

- ☐ Hepsera
- ☐ 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