PREFERRED SPECIALTY MANAGEMENT POLICY

POLICY: Hepatitis C Virus Direct-Acting Antivirals Preferred Specialty Management Policy for National Preferred Formulary and Basic Formulary

- Epclusa® (sofosbuvir/velpatasvir tablets and oral pellets – Gilead)
- sofosbuvir/velpatasvir tablets (authorized generic to Epclusa 400 mg/100 mg tablets – Gilead)
- Harvoni® (ledipasvir/sofosbuvir tablets and oral pellets – Gilead)
- ledipasvir/sofosbuvir tablets (authorized generic to Harvoni – Gilead)
- Mavyret® (glecaprevir/pibrentasvir tablets and oral pellets – AbbVie)
- Sovaldi® (sofosbuvir tablets and oral pellets – Gilead)
- Vosevi® (sofosbuvir/velpatasvir/voxilaprevir tablets – Gilead)
- Zepatier® (grazoprevir/elbasvir tablets – Merck)

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OVERVIEW

The standard of care for all Hepatitis C genotypes is all-oral therapy with direct-acting antivirals. For more information on criteria within a Prior Authorization program by specific condition, refer to the respective standard *Hepatitis C Prior Authorization Policy*.

All of the direct-acting antivirals (DAAs) are indicated for the treatment of **chronic hepatitis C virus** (HCV). Epclusa is indicated for the treatment of HCV genotypes 1 through 6 in patients ≥ 3 years of age with or without compensated cirrhosis or with decompensated cirrhosis in combination with ribavirin.[4] Harvoni is indicated for the treatment of patients ≥ 3 years of age: 1) with genotypes 1, 4, 5, and 6 chronic HCV with or without compensated cirrhosis; 2) with genotype 1 chronic HCV with decompensated cirrhosis; and 3) with genotype 1 or 4 infection in liver transplant recipients without cirrhosis or with compensated cirrhosis, in combination with ribavirin.[1] Mavyret is indicated for the treatment of patients ≥ 3 years of age with chronic HCV genotype 1, 2, 3, 4, 5, or 6 infection with or without compensated cirrhosis and for the treatment of patients ≥ 3 years of age with HCV genotype 1 infection who have previously been treated with a regimen containing an HCV NS5A inhibitor or an NS3/4A protease inhibitor, but not both.[6] Mavyret is additionally indicated in kidney and liver transplant patients with specific dosing for these patient populations. Sovaldi is indicated for the treatment of adults with genotypes 1, 2, 3, and 4 chronic HCV in combination with ribavirin or pegylated interferon + ribavirin.[2] Sovaldi is also indicated in pediatric patients ≥ 3 years of age with genotypes 2 or 3 chronic HCV in combination with ribavirin. Vosevi is indicated for the treatment of adults with chronic HCV infection with or without compensated cirrhosis in the following types of patients: Patients with genotype 1, 2, 3, 4, 5, or 6 infection who have previously been treated with an HCV regimen containing an NS5A inhibitor; and for patients with genotype 1a or 3 infection and who have previously been treated with an HCV regimen containing Sovaldi without an NS5A inhibitor.[5] Zepatier is indicated for the treatment of patients ≥ 12 years (or ≥ 30 kg) with genotypes 1 and 4 chronic HCV.[3]

Epclusa and Harvoni are the available products indicated in decompensated liver disease.

POLICY STATEMENT

This Preferred Specialty Management program has been developed to encourage the use of Preferred Products. For all medications (Preferred and Non-Preferred), the patient is required to meet the respective standard *Hepatitis C Prior Authorization Policy* criteria. The program also directs the patient to try one Preferred Product. Requests for Non-Preferred Products will also be reviewed using the exception criteria (below). If the patient meets the standard *Hepatitis C Prior Authorization Policy* criteria, but has not tried a Preferred Product, a review will be offered for the Preferred Product using the respective standard *Hepatitis C Prior Authorization Policy* criteria. All approvals are provided for the duration documented in the respective standard *Hepatitis C Prior Authorization Policy*.

Documentation: Documentation is required for use of a non-preferred product as noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and/or other information.

Automation: None.

National Preferred Formulary and Basic Formulary - Preferred and Non-Preferred Products for Chronic Hepatitis C Virus.

	Genotype 1	Genotype 2	Genotype 3	Genotype 4	Genotype 5 or 6
Preferred	• Epclusa (brand) • Harvoni (brand) • Vosevi • Zepatier	• Epclusa (brand) • Vosevi	• Epclusa (brand) • Vosevi	• Epclusa (brand) • Harvoni (brand) • Vosevi • Zepatier	• Epclusa (brand) • Harvoni (brand) • Vosevi
Non-Preferred	• Mavyret • sofosbuvir/ velpatasvir (generic) • ledipasvir/ sofosbuvir (generic)	• Mavyret • Sovaldi • sofosbuvir/ velpatasvir (generic)	• Mavyret • Sovaldi • sofosbuvir/ velpatasvir (generic)	• Mavyret • sofosbuvir/ velpatasvir (generic) • ledipasvir/ sofosbuvir (generic)	• Mavyret • sofosbuvir/ velpatasvir (generic) • ledipasvir/ sofosbuvir (generic)

*Note: Epclusa oral pellets and Harvoni oral pellets are only available as a brand product. The authorized generics are not available as oral pellets.

RECOMMENDED EXCEPTION CRITERIA

Non-Preferred Product	Exception Criteria
Epclusa (brand only)	**1.** Approve for the duration specified in the standard *Hepatitis C – Epclusa PA Policy* if the patient has met the standard *Hepatitis C – Epclusa PA Policy* criteria.
sofosbuvir/ velpatasvir (generic only)	**1.** Sofosbuvir/velpatasvir (generic only) is not approved; offer to review for Epclusa (brand only) using the standard *Hepatitis C – Epclusa PA Policy* criteria.
Harvoni (brand only)	**1.** Approve for the duration specified in the standard *Hepatitis C – Harvoni PA Policy* if the patient has met the standard *Hepatitis C – Epclusa PA Policy* criteria.
ledipasvir/ sofosbuvir (generic only)	**1.** Ledipasvir/sofosbuvir (generic only) is not approved; offer to review for Harvoni (brand only) using the standard *Hepatitis C – Harvoni PA Policy* criteria.

Sovaldi	**1. Genotype 2 or 3 Chronic Hepatitis C Virus, Pediatric Patient (≥ 3 Years of Age and < 18 Years of Age) – New Start.** Sovaldi is not approved. Offer to review for Epclusa (brand only) using the standard *Hepatitis C – Epclusa PA Policy* criteria. **2. Patient Continuing Therapy with Sovaldi.** Refer to the standard *Hepatitis C – Sovaldi PA Policy* criteria.
Mavyret	**1. Genotype 1 Chronic Hepatitis C Virus Adults (≥ 18 years of age) – New Start.** **A)** Patient is treatment-naïve: Mavyret is not approved. Offer to review for Epclusa (brand only), Harvoni (brand only), or Zepatier using the respective *Hepatitis C PA Policy* criteria; OR **B)** Approve for the duration specified in the *Hepatitis C – Mavyret PA for PSM Policy* if the patient meets BOTH of the following criteria (i and ii): **i.** Patient has met the *Hepatitis C* – Mavyret PA for PSM Policy criteria; AND **ii.** Patient meets ONE of the following criteria (a, b, or c): **a)** Patient has previously been treated with pegylated interferon/ribavirin, Incivek, Olysio, or Victrelis AND meets the following criteria (1): **(1)** Patient has completed a course of therapy with ONE of Epclusa (brand or generic), Harvoni (brand or generic), or Zepatier and has documentation that the patient did not achieve a sustained viral response (SVR; virus undetectable 12 weeks following completion of therapy) with the respective therapy **[documentation required]**; OR **b)** Patient has previously been treated with Daklinza, Epclusa (brand or generic), Harvoni (brand or generic), or Zepatier and meets the following criteria (1): **(1)** Patient has completed a course of therapy with Vosevi and has documentation that the patient did not achieve a sustained viral response (SVR; virus undetectable 12 weeks following completion of therapy) with the respective therapy **[documentation required]**; OR **c)** Patient has previously been treated with Sovaldi + ribavirin ± pegylated interferon/interferon OR Sovaldi + Olysio. **C)** Patient meets criteria 1Bi and 1Biia but NOT 1Biia(1): offer to review for Epclusa (brand only), Harvoni (brand only), Vosevi, or Zepatier using the respective standard *Hepatitis C PA Policy* criteria. **D)** Patient meets criteria 1Bi and 1Biib but NOT 1Biib(1): offer to review for Vosevi using standard *Hepatitis C – Vosevi PA Policy* criteria. **2. Genotype 1 Chronic Hepatitis C Virus, Pediatric Patient (≥ 3 Years of Age and < 18 Years of Age) – New Start.** **A)** Patient is treatment-naïve: Mavyret is not approved. Offer to review for Epclusa (brand only) or Harvoni (brand only) using the respective *Hepatitis C PA Policy* criteria; OR **B)** Approve for the duration specified in the *Hepatitis C – Mavyret PA for PSM Policy* if the patient meets BOTH of the following criteria (i and ii): **i.** Patient has met the *Hepatitis C – Mavyret PA for PSM Policy* criteria; AND **ii.** Patient meets ONE of the following criteria (a, b, or c):

	a) Patient has previously been treated with pegylated interferon/ribavirin, Incivek, Olysio, or Victrelis AND meets the following criteria (1): **(1)** Patient has completed a course of therapy with ONE of Epclusa (brand or generic) or Harvoni (brand or generic) and has documentation that the patient did not achieve a sustained viral response (SVR; virus undetectable 12 weeks following completion of therapy) with the respective therapy **[documentation required]**; OR **b)** Patient has previously been treated with Daklinza, Epclusa (brand or generic), Harvoni (brand or generic), or Zepatier; OR **c)** Patient has previously been treated with Sovaldi + ribavirin ± pegylated interferon/interferon OR Sovaldi + Olysio. **C)** Patient meets criteria 2Bi and 2Biia but NOT 2Biia(1): offer to review for Epclusa (brand only) or Harvoni (brand only) using the respective standard *Hepatitis C PA Policy* criteria. **3. Genotype 2 Chronic Hepatitis C Virus – New Start.** **A)** Patient is treatment-naïve: Mavyret is not approved. Offer to review for Epclusa (brand only) using the standard *Hepatitis C – Epclusa PA Policy* criteria; OR **B)** Approve for the duration specified in the *Hepatitis C – Mavyret PA for PSM Policy* if the patient meets BOTH of the following criteria (i and ii): **i.** Patient has met the *Hepatitis C – Mavyret PA for PSM Policy* criteria; AND **ii.** Patient meets ONE of the following criteria (a or b): **a)** Patient has previously been treated with pegylated interferon/ribavirin AND meets the following criteria (1): **(1)** Patient has completed a course of therapy with Epclusa (brand or generic) and has documentation that the patient did not achieve a sustained viral response (SVR; virus undetectable 12 weeks following completion of therapy) with the respective therapy **[documentation required]**; OR **b)** Patient has previously been treated with Sovaldi + ribavirin ± pegylated interferon/interferon. **C)** Patient meets criteria 3Bi and 3Biia but NOT 3Biia(1); offer to review for Epclusa (brand only) using the standard *Hepatitis C – Epclusa PA Policy* criteria. **4. Genotype 3 Chronic Hepatitis C Virus Pediatric Patient (≥ 3 Years of Age and < 18 Years of Agee) – New Start.** **A)** Patient is treatment-naïve: Mavyret is not approved. Offer to review for Epclusa (brand only) using the standard *Hepatitis C – Epclusa PA Policy* criteria; OR **B)** Approve for the duration specified in the *Hepatitis C – Mavyret PA for PSM Policy* if the patient meets BOTH of the following criteria (i and ii): **i.** Patient has met the standard *Hepatitis C – Mavyret PA for PSM* criteria; AND **ii.** Patient meets ONE of the following criteria (a or b): **a)** Patient has previously been treated with pegylated interferon/ribavirin AND meets the following criteria (1):

	(1) Patient has completed a course of therapy with Epclusa (brand or generic) and has documentation that the patient did not achieve a sustained viral response (SVR; virus undetectable 12 weeks following completion of therapy) with the respective therapy **[documentation required]**; OR **b)** Patient has previously been treated with Sovaldi + ribavirin ± pegylated interferon/interferon. **C)** Patient meets criteria 4Bi and 4Biia but NOT 4Biia(1): offer to review for Epclusa (brand only) using the standard *Hepatitis C – Epclusa PA Policy* criteria. **5. Genotype 3 Chronic Hepatitis C Virus, Adult (≥ 18 Years of Age) – New Start.** **A)** Patient is treatment-naïve: Mavyret is not approved. Offer to review for Epclusa (brand only) using the standard *Hepatitis C – Epclusa PA Policy* criteria; OR **B)** Approve for the duration specified in the *Hepatitis C – Mavyret PA for PSM Policy* if the patient meets BOTH of the following criteria (i and ii): **i.** Patient has met the standard *Hepatitis C – Mavyret PA for PSM* criteria; AND **ii.** Patient meets ONE of the following criteria (a or b): **a)** Patient has previously been treated with pegylated interferon/ribavirin AND meets the following criteria (1): **(1)** Patient has completed a course of therapy with Epclusa (brand or generic) and has documentation that the patient did not achieve a sustained viral response (SVR; virus undetectable 12 weeks following completion of therapy) with the respective therapy **[documentation required]**; OR **b)** Patient has previously been treated with Sovaldi + ribavirin ± pegylated interferon/interferon and meets the following criteria (1): **(1)** The patient has completed a course of therapy with Vosevi and has documentation that the patient did not achieve a sustained viral response (SVR; virus undetectable 12 weeks following completion of therapy) with the respective therapy **[documentation required].** **C)** Patient meets criteria 5Bi and 5Biia but NOT 5Biia(1): offer to review for Epclusa (brand only) using the standard *Hepatitis C – Epclusa PA Policy* criteria. **D)** Patient meets criteria 5Bi and 5Biib but NOT 5Biib(1): offer to review for Vosevi, using the standard *Hepatitis C – Vosevi PA Policy* criteria. **6. Genotype 4 Chronic Hepatitis C Virus, Adult (≥ 18 Years of Age) – New Start.** **A)** Patient is treatment-naïve: Mavyret is not approved. Offer to review for Epclusa (brand only), Harvoni (brand only), or Zepatier using the respective standard *Hepatitis C PA Policy* criteria; OR **B)** Approve for the duration specified in the *Hepatitis C – Mavyret PA for PSM Policy* if the patient meets BOTH of the following criteria (i and ii): **i.** Patient has met the *Hepatitis C – Mavyret PA for PSM Policy* criteria; AND **ii.** Patient meets ONE of the following criteria (a or b): **a)** Patient has previously been treated with pegylated interferon/ribavirin AND meets the following criteria (1):

	(1) Patient has completed a course of therapy with Epclusa (brand or generic), Harvoni (brand or generic), or Zepatier, and has documentation that the patient did not achieve a sustained viral response (SVR; virus undetectable 12 weeks following completion of therapy) with the respective therapy **[documentation required]**; OR **b)** Patient has previously been treated with Sovaldi + ribavirin ± pegylated interferon/interferon. **C)** Patient meets criteria 6Bi and 6Biia but NOT 6Biia(1); offer to review for Epclusa (brand only), Harvoni (brand only), or Zepatier using the respective standard *Hepatitis C PA Policy* criteria. **7. Genotype 4 Chronic Hepatitis C Virus, Pediatric Patient (≥ 3 Years of Age and < 18 Years of Age) – New Start.** **A)** Patient is treatment-naïve: Mavyret is not approved. Offer to review for Epclusa (brand only) or Harvoni (brand only) using the respective standard *Hepatitis C PA Policy* criteria; OR **B)** Approve for the duration specified in the *Hepatitis C – Mavyret PA for PSM Policy* if the patient meets BOTH of the following criteria (i and ii): **i.** Patient has met the *Hepatitis C – Mavyret PA for PSM Policy* criteria; AND **ii.** Patient meets ONE of the following criteria (a or b): **a)** Patient has previously been treated with pegylated interferon/ribavirin AND meets the following criteria (1): **(1)** Patient has completed a course of therapy with Epclusa (brand or generic) or Harvoni (brand or generic) and has documentation that the patient did not achieve a sustained viral response (SVR; virus undetectable 12 weeks following completion of therapy) with the respective therapy **[documentation required]**; OR **b)** Patient has previously been treated with Sovaldi + ribavirin ± pegylated interferon/interferon. **C)** Patient meets criteria 7Bi and 7Biia but NOT 7Biia(1); offer to review for Epclusa (brand only) or Harvoni (brand only) using the respective standard *Hepatitis C PA Policy* criteria. **8. Genotype 5 or 6 Chronic Hepatitis C Virus – New Start.** **A)** Patient is treatment-naïve: Mavyret is not approved: Offer to review for Epclusa (brand only) or Harvoni (brand only) using the respective standard *Hepatitis C PA Policy* criteria; OR **B)** Approve for the duration specified in the *Hepatitis C – Mavyret PA for PSM Policy* if the patient meets BOTH of the following criteria (i and ii): **i.** Patient has met the *Hepatitis C – Mavyret PA for PSM Policy* criteria; AND **ii.** Patient meets ONE of the following criteria (a or b): **a)** Patient has previously been treated with pegylated interferon/ribavirin AND meets the following criteria (1): **(1)** Patient has completed a course of therapy with Epclusa (brand or generic) or Harvoni (brand or generic) and has documentation that the patient did not achieve a sustained viral response (SVR; virus undetectable 12 weeks following completion of therapy) with the respective therapy **[documentation required]**; OR

	b) Patient has previously been treated with Sovaldi + ribavirin ± pegylated interferon/interferon. **C)** Patient meets criteria 8Bi and 8Biia but NOT 8Biia(1): offer to review for Epclusa (brand only) or Harvoni (brand only) using the respective standard *Hepatitis C PA Policy* criteria. **9. Genotype 1 Hepatitis C Virus with Renal Impairment (Estimated Glomerular Filtration Rate [eGFR] < 30 mL/min or End-Stage Renal Disease [ESRD]), Adult (≥ 18 Years of Age) – New Start.** **A)** Patient is treatment-naïve: Mavyret is not approved. Offer to review for Zepatier using the standard *Hepatitis C – Zepatier PA Policy* criteria; OR **B)** Approve for the duration specified in the *Hepatitis C – Mavyret PA for PSM Policy* if the patient meets BOTH of the following criteria (i and ii): **i.** Patient has met the *Hepatitis C – Mavyret PA for PSM Policy* criteria; AND **ii.** Patient meets ONE of the following criteria (a or b): **a)** Patient has previously been treated with pegylated interferon/ribavirin, Incivek, Olysio, or Victrelis and meets the following criteria (1): **(1)** Patient has completed a course of therapy with Zepatier and has documentation that the patient did not achieve a sustained viral response (SVR; virus undetectable 12 weeks following completion of therapy) with the respective therapy **[documentation required]**; OR **b)** Patient has previously been treated with Sovaldi + ribavirin ± pegylated interferon/interferon, or Sovaldi + Olysio, or Daklinza, or Epclusa (brand or generic), or Harvoni (brand or generic), or Zepatier. **C)** Patient meets criteria 9Bi and 9Biia but NOT 9Biia(1): offer to review for Zepatier using the standard *Hepatitis C – Zepatier PA Policy* criteria. **10. Genotype 4 Hepatitis C Virus with Renal Impairment (Estimated Glomerular Filtration Rate [eGFR] < 30 mL/min or End-Stage Renal Disease [ESRD]), Adult (≥ 18 Years of Age) – New Start.** **A)** Patient is treatment-naïve: Mavyret is not approved. Offer to review for Zepatier using the standard *Hepatitis C – Zepatier PA Policy* criteria; OR **B)** Approve for the duration specified in the *Hepatitis C – Mavyret PA for PSM Policy* if the patient meets BOTH of the following criteria (i and ii): **i.** Patient has met the *Hepatitis C – Mavyret PA for PSM Policy* criteria; AND **ii.** Patient meets ONE of the following criteria (a or b): **a)** Patient has previously been treated with pegylated interferon/ribavirin and meets the following criteria (1): **(1)** Patient has completed a course of therapy with Zepatier and has documentation that the patient did not achieve a sustained viral response (SVR; virus undetectable 12 weeks following completion of therapy) with Zepatier **[documentation required]**; OR **b)** Patient has previously been treated with Sovaldi + ribavirin ± pegylated interferon/interferon. **C)** Patient meets criteria 10Bi and 10Biia but NOT 10Biia(1): offer to review for Zepatier using the standard *Hepatitis C – Zepatier PA Policy* criteria.

	11. Genotype 1 or 4 Hepatitis C Virus in a Patient with Renal Impairment (Estimated Glomerular Filtration Rate [eGFR] < 30 mL/min or End-Stage Renal Disease [ESRD]), Pediatric Patient (≥ 3 Years of Age and < 18 Years of Age) – New Start. Approve for the duration specified in the *Hepatitis C – Mavyret PA for PSM Policy* criteria if the patient has met the *Hepatitis C – Mavyret PA for PSM Policy* criteria. **12. Genotype 2, 3, 5, or 6 Hepatitis C Virus with Renal Impairment (Estimated Glomerular Filtration Rate [eGFR] < 30 mL/min or End-Stage Renal Disease [ESRD]) – New Start.** Approve for the duration specified in the *Hepatitis C – Mavyret PA for PSM Policy* criteria if the patient has met the *Hepatitis C – Mavyret PA for PSM Policy* criteria. **13. Genotype 1, 2, 3, 4, 5, or 6 Hepatitis C Virus, Kidney Transplant – New Start.** Approve for the duration specified in the *Hepatitis C – Mavyret PA for PSM Policy* criteria if the patient has met the *Hepatitis C – Mavyret PA for PSM Policy* criteria. **14. Genotype 2, or 3 Recurrent Hepatitis C Virus Post-Liver Transplantation – New Start.** Approve for the duration specified in the *Hepatitis C – Mavyret PA for PSM Policy* criteria if the patient has met the *Hepatitis C – Mavyret PA for PSM Policy* criteria. **15. Genotype 1, 4, 5, or 6 Recurrent Hepatitis C Virus Post-Liver Transplantation – New Start, Adult (≥ 18 Years of Age).** **A)** Approve for the duration specified in the *Hepatitis C – Mavyret PA for PSM Policy* if the patient meets the following criteria (i and ii): **i.** Patient has met the *Hepatitis C – Mavyret PA for PSM Policy* criteria; AND **ii.** Patient has completed a course of therapy with Harvoni (brand or generic) and has documentation that the patient did not achieve a sustained viral response (SVR; virus undetectable 12 weeks following completion of therapy) with Harvoni (brand or generic) **[documentation required]**. **B)** Patient meets criteria 15Ai but NOT 15Aii: offer to review for Harvoni (brand only) using the standard *Hepatitis C – Harvoni PA Policy* criteria. **16. Genotype 1, 4, 5, or 6 Recurrent Hepatitis C Virus Post-Liver Transplantation – New Start, Pediatric (≥ 3 Years of Age and < 18 Years of Age).** Approve for the duration specified in the *Hepatitis C – Mavyret PA for PSM Policy* criteria if the patient has met the *Hepatitis C – Mavyret PA for PSM Policy* criteria. **17. Genotype 1, 2, 3, 4, 5, or 6 Hepatitis C Virus Liver Transplant Recipient – New Start.** Approve for the duration specified in the *Hepatitis C – Mavyret PA for PSM Policy* criteria if the patient has met the *Hepatitis C – Mavyret PA for PSM Policy* criteria. **18. Patient Continuing Therapy with Mavyret.** Refer to the *Hepatitis C – Mavyret PA for PSM Policy* criteria.
Vosevi	**1. Genotype 1, 2, 3, 4, 5, or 6 chronic Hepatitis C Virus.** Approve for the duration specified in the standard *Hepatitis C – Vosevi PA Policy* criteria if the patient has met the standard *Hepatitis C – Vosevi PA Policy* criteria. **2. Patient Continuing Therapy with Vosevi.** Refer to the standard *Hepatitis C – Vosevi PA Policy* criteria.
Zepatier	**1. Genotype 1 or 4 Chronic Hepatitis C Virus – New Start.** Approve for the duration specified in the standard *Hepatitis C – Zepatier PA Policy* criteria if the patient has met the standard *Hepatitis C – Zepatier PA Policy* criteria.

	2. Patient Continuing Therapy with Zepatier. Refer to the standard *Hepatitis C – Zepatier PA Policy* criteria.

REFERENCES

1. Harvoni® tablets and oral pellets [prescribing information]. Foster City, CA: Gilead; March 2020.
2. Sovaldi® tablets and oral pellets [prescribing information]. Foster City, CA: Gilead; March 2020.
3. Zepatier® tablets [prescribing information]. Whitehouse Station, NJ: Merck; December 2021.
4. Epclusa® tablets and oral pellets [prescribing information]. Foster City, CA: Gilead; April 2022.
5. Vosevi® tablets [prescribing information]. Foster City, CA: Gilead; November 2019.
6. Mavyret® tablets and oral pellets [prescribing information]. North Chicago, IL: AbbVie; September 2021.