DRUG QUANTITY MANAGEMENT POLICY – PER DAYS

POLICY: Hepatitis C – Mavyret Drug Quantity Management Policy – Per Days
- Mavyret® (glecaprevir/pibrentasvir tablets and oral pellets – AbbVie)

REVIEW DATE: 11/05/2025

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Mavyret, a direct-acting antiviral, contains glecaprevir, a pangenotypic NS3/4A protease inhibitor and pibrentasvir, a pangenotypic NS5A inhibitor.[1] It is indicated for the treatment of **acute or chronic hepatitis C virus** (HCV) in patients ≥ 3 years of age with genotype 1, 2, 3, 4, 5, or 6 infection without cirrhosis or with compensated cirrhosis (Child-Pugh A). It is indicated in patients ≥ 3 years of age with 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.

Dosing

Duration of Therapy

The duration of therapy is based on prior treatment experience, genotype, and the presence or absence of cirrhosis (see Tables 1 and 2).[1] In addition, Mavyret is recommended for 12 weeks in patients ≥ 3 years of age who are liver or kidney

transplant recipients. Similar to non-transplant recipients, a 16-week treatment duration is recommended in genotype 1-infected patients who are NS5A inhibitor-experienced without prior treatment with an NS3/4A protease inhibitor or in genotype 3-infected patients who are treatment-experienced with regimens containing interferon, pegylated interferon, ribavirin, and/or Sovaldi® (sofosbuvir tablets/oral pellets). The clinical trial in patients with acute HCV assessed Mavyret for 8 weeks.

Table 1. Recommended Duration for Treatment-Naïve Patients.[1]

HCV Genotype	Treatment Duration	
	No Cirrhosis	Compensated Cirrhosis (Child-Pugh A)
1, 2, 3, 4, 5, or 6	8 weeks	8 weeks

HCV – Hepatitis C virus.

Table 2. Recommended Duration for Treatment-Experienced Patients.[1*]

HCV Genotype	Prior Treatment Experience	Duration	
		Without Cirrhosis	With Compensated Cirrhosis (Child-Pugh A)
1, 2, 4, 5, 6	PRS	8 weeks	12 weeks
3	PRS	16 weeks	16 weeks
1	NS3/4 PI[1] (NS5A-naïve)	12 weeks	12 weeks
	NS5A inhibitor[2] (NS3/4 PI-naïve)[†]	16 weeks	16 weeks

[*] Treatment-experienced patients are those who previously received treatment for the current infection; HCV – Hepatitis C virus; PRS – Prior treatment experience with regimens containing interferon, pegylated interferon, ribavirin, and/or Sovaldi® (sofosbuvir tablets), but no prior treatment experience with an HCV NS3/4A protease inhibitor (PI) or NS5A inhibitor; PI – Protease inhibitor; [1] Regimens containing Olysio® (simeprevir capsules) and Sovaldi, or Olysio, Victrelis® (boceprevir capsules), or Incivek® (telaprevir tablets) with interferon or pegylated interferon and ribavirin were studied; [2] Regimens containing ledipasvir/sofosbuvir or Daklinza® (daclatasvir tablets) + pegylated interferon + ribavirin [unapproved regimen] were studied.

Dosing

The recommended dose of Mavyret for adults and pediatric patients ≥ 12 years of age or who weigh ≥ 45 kg, is three tablets (total daily dose: glecaprevir 300 mg and pibrentasvir 120 mg) taken once daily (QD) with food.[1] The recommended dosing for patients 3 to < 12 years of age is weight-based given QD and is outlined in Table 3. The Mavyret oral pellets are recommended for use in patients 3 to < 12 years of age or patients who weigh < 45 kg. Mavyret tablets are intended for use in patients ≥ 12 years of age or pediatric patients who weigh ≥ 45 kg. In pediatric patients who weigh ≥ 45 kg and are unable to swallow tablets, six of the 50 mg/200 mg packets of oral pellets may be used.

Table 3. Recommended Mavyret Dosing in Patients ≥ 3 Years of Age.[1]

Body Weight/Age	Daily Dose of glecaprevir/pibrentasvir	Mavyret Dosing
< 20 kg	150 mg/60 mg per day	Three 50 mg/20 mg packets of oral pellets QD
20 kg to < 30 kg	200 mg/80 mg per day	Four 50 mg/20 mg packets of oral pellets QD
30 kg to < 45 kg	250 mg/100 mg per day	Five 50 mg/20 mg packets of oral pellets QD

≥ 45 kg OR ≥ 12 years of age	300 mg/120 mg per day	Three 100 mg/40 mg **tablets** QD† (refer to Recommended Dosage in Adults)

QD – Once daily; † Pediatric patients weighing ≥ 45 kg who are unable to swallow tablets may take six 50 mg/20 mg packets of oral pellets once daily. Dosing with oral pellets has not been studied for pediatric patients weighing > 45 kg.

Availability

Mavyret is available as a fixed-dose combination tablet containing glecaprevir 100 mg and pibrentasvir 40 mg and an oral pellet packet containing glecaprevir 50 mg and pibrentasvir 20 mg.[1]

Mavyret tablets are supplied in 4-week (monthly) cartons and bottles.[1] In the cartons, the tablets are packaged in daily dose blisters or wallets that each contain three 100 mg/40 mg tablets. Each weekly carton contains seven daily dose blisters or wallets. Each monthly carton contains four weekly cartons. Bottles contain 84 x 100 mg/40 mg tablets.

Mavyret oral pellets are supplied in child-resistant unit-dose packets, containing 50 mg glecaprevir/20 mg pibrentasvir each.[1] Each carton contains 28 packets.

Guidelines

The current web-based treatment recommendations by the American Association for the Study of Liver Diseases and the Infectious Diseases Society of America provide guidance for treating patients with chronic HCV infection.[2] Consult the guidance for the most up-to-date information.

POLICY STATEMENT

This Drug Quantity Management program has been developed to prevent stockpiling, misuse and/or overuse of Mavyret. If the Drug Quantity Management rule is not met for the requested medication at the point of service, coverage will be determined by the Criteria below. All approvals are provided for the duration noted below.

Drug Quantity Limits

Product	Strength and Form	Retail and Home Delivery Maximum Quantity*
Mavyret® (glecaprevir/pibrentasvir tablets and oral pellets)	100 mg/40 mg tablets	168 tablets per 365 days (84 tablets per dispensing)
	50 mg/20 mg pellet packets	336 packets per 365 days (168 packets per dispensing)

* This is a quantity sufficient for 8 weeks of treatment with the tablets at the recommended dose (300 mg/120 mg once daily) and 8 weeks of treatment with the pellet packets at the maximal recommended dose of six packets of pellets once daily.

EXCEPTIONS TO THE QUANTITY LIMITS LISTED ABOVE ARE COVERED AS MEDICALLY NECESSARY WHEN THE FOLLOWING CRITERIA ARE MET. ANY OTHER EXCEPTION IS CONSIDERED NOT MEDICALLY NECESSARY.

CRITERIA

1. **Chronic Hepatitis C Virus, Genotype 1, Treatment-Experienced, NS5A-Experienced, NS3/4-Naïve.** Approve 336 tablets or 672 pellet packets per 365 days at retail or home delivery if the patient meets ALL of the following criteria (A, B, and C):
   Note: This is a quantity sufficient for 16 weeks of therapy.
   A) Patient does not have cirrhosis or has compensated cirrhosis (Child-Pugh A); AND
   B) Patient had a prior null response, prior partial response, or had relapse after prior treatment with one of the following NS5A-inhibitor containing products: Daklinza (daclatasvir tablets), sofosbuvir/velpatasvir, or ledipasvir/sofosbuvir; AND
   C) Patient has not previously been treated with one of the following NS3/4A inhibitors or NS3/4A inhibitor-containing products: Olysio (simeprevir capsules), Victrelis (boceprevir capsules), or Incivek (telaprevir tablets), Technivie (ombitasvir/paritaprevir/ritonavir tablets), Viekira Pak (ombitasvir/paritaprevir/ritonavir tablets; dasabuvir tablets, co-packaged), Viekira XR (dasabuvir/ombitasvir/paritaprevir/ritonavir extended-release tablets), Vosevi (sofosbuvir/velpatasvir/voxilaprevir tablets), or Zepatier (elbasvir/grazoprevir tablets).

2. **Chronic Hepatitis C Virus, Genotype 1, Treatment-Experienced, NS3/4-Experienced, NS5A-Naïve.** Approve 252 tablets or 504 pellet packets per 365 days at retail or home delivery if the patient meets ALL of the following criteria (A, B, and C):
   Note: This is a quantity sufficient for 12 weeks of therapy.
   A) Patient does not have cirrhosis or has compensated cirrhosis (Child-Pugh A); AND
   B) Patient has not previously been treated with one of the following NS5A-inhibitor containing products: Daklinza (daclatasvir tablets), sofosbuvir/velpatasvir, ledipasvir/sofosbuvir, Technivie (ombitasvir/paritaprevir/ritonavir tablets), Viekira Pak (ombitasvir/paritaprevir/ritonavir tablets; dasabuvir tablets, co-packaged), Viekira XR (dasabuvir/ombitasvir/paritaprevir/ritonavir extended-release tablets), Vosevi (sofosbuvir/velpatasvir/voxilaprevir tablets), or Zepatier (elbasvir/grazoprevir tablets); AND
   C) Patient had a prior null response, prior partial response, or had relapse after prior treatment with one of the following NS3/4A inhibitors or NS3/4A inhibitor-containing products: Olysio (simeprevir capsules), Victrelis (boceprevir capsules), or Incivek (telaprevir tablets).

3. **Chronic Hepatitis C Virus, Genotype 1, 2, 4, 5, and 6 Treatment-Experienced, Pegylated Interferon/Interferon, Ribavirin, Sovaldi-Experienced.** Approve 252 tablets or 504 pellet packets per 365 days at retail or home delivery if the patient meets BOTH of the following criteria (A and B):
   Note: This is a quantity sufficient for 12 weeks of therapy.
   A) Patient has compensated cirrhosis (Child-Pugh A); AND
   B) Patient had a prior null response, prior partial response, or had relapse after prior treatment with one of the following regimens: interferon ± ribavirin, pegylated interferon ± ribavirin, Sovaldi (sofosbuvir tablets/oral pellets) + ribavirin, Sovaldi (sofosbuvir tablets/oral pellets) + pegylated interferon + ribavirin.

4. **Chronic Hepatitis C Virus, Genotype 3, Treatment-Experienced, Pegylated Interferon/Interferon, Ribavirin, Sovaldi-Experienced.** Approve 336 tablets or 672 pellet packets per 365 days at retail or home delivery if the patient meets BOTH of the following criteria (A and B):
   Note: This is a quantity sufficient for 16 weeks of therapy.
   A) Patient does not have cirrhosis or has compensated cirrhosis (Child-Pugh A); AND
   B) Patient had a prior null response, prior partial response, or had relapse after prior treatment with one of the following regimens: interferon ± ribavirin, pegylated interferon ± ribavirin, Sovaldi (sofosbuvir tablets/oral pellets) + ribavirin, Sovaldi (sofosbuvir tablets/oral pellets) + pegylated interferon + ribavirin.

5. **Recurrent Hepatitis C Virus (HCV) Post-Liver Transplantation, Genotype 1, 2, 3, 4, 5, OR 6.** Approve 252 tablets or 504 pellet packets per 365 days at retail or home delivery.
   Note: This is a quantity sufficient for 12 weeks of therapy.

6. **Hepatitis C Virus (HCV) Kidney or Liver Transplant Recipients, Genotype 2, 4, 5, 6.** Approve 252 tablets or 504 pellet packets per 365 days at retail or home delivery.
   Note: This is a quantity sufficient for 12 weeks of therapy.

7. **Hepatitis C Virus (HCV) Kidney or Liver Transplant Recipients, Genotype 1.** Approve for the duration below if the patient meets ONE of the following conditions (A or B):
   A) NS5A-Experienced, NS3/4-Naïve: Approve 336 tablets or 672 pellet packets per 365 days at retail or home delivery if the patient meets BOTH of the following criteria (i and ii):
      Note: This is a quantity sufficient for 16 weeks of therapy.
      i. Patient had a prior null response, prior partial response, or had relapse after prior treatment with one of the following NS5A-inhibitor containing products: Daklinza (daclatasvir tablets), sofosbuvir/velpatasvir, ledipasvir/sofosbuvir; AND
      ii. Patient has not previously been treated with one of the following NS3/4A inhibitors or NS3/4A inhibitor-containing products: Olysio (simeprevir

capsules), Victrelis (boceprevir capsules), Incivek (telaprevir tablets), Technivie (ombitasvir/paritaprevir/ritonavir tablets), Viekira Pak (ombitasvir/paritaprevir/ritonavir tablets; dasabuvir tablets, co-packaged), Viekira XR (dasabuvir/ombitasvir/paritaprevir/ritonavir extended-release tablets), Vosevi (sofosbuvir/velpatasvir/voxilaprevir tablets); or Zepatier (elbasvir/grazoprevir tablets); OR

B) All Other Patients with Genotype 1: Approve 252 tablets or 504 pellet packets per 365 days at retail or home delivery.
Note: This is a quantity sufficient for 12 weeks of therapy.

8. Hepatitis C Virus (HCV) Kidney or Liver Transplant Recipients, Genotype 3. Approve for the duration below if the patient meets ONE of the following conditions (A or B):

A) Pegylated Interferon/Interferon, Ribavirin, Sovaldi-Experienced: Approve 336 tablets or 672 pellet packets per 365 days at retail or home delivery if the patient had a prior null response, prior partial response, or had relapse after prior treatment with one of the following regimens: interferon ± ribavirin, pegylated interferon ± ribavirin, Sovaldi (sofosbuvir tablets/oral pellets) + ribavirin, Sovaldi (sofosbuvir tablets/oral pellets) + pegylated interferon + ribavirin; OR
Note: This is a quantity sufficient for 16 weeks of therapy.

B) All Other Patients with Genotype 3: Approve 252 tablets or 504 pellet packets per 365 days at retail or home delivery.
Note: This is a quantity sufficient for 12 weeks of therapy.

9. For an indication or condition addressed as an approval in the above criteria, approve the quantity described above to complete a course therapy at retail or home delivery.
Note: For example, if a patient who should receive 12 weeks of Mavyret tablets (252 tablets) has received 3 weeks of Mavyret tablets (63 tablets) then approve a quantity sufficient for 9 weeks of Mavyret tablets (189 tablets) to complete their 12-week course of therapy at retail or home delivery.

REFERENCES

1. Mavyret® tablets [prescribing information]. North Chicago, IL: AbbVie; June 2025.
2. American Association for the Study of Liver Diseases and the Infectious Diseases Society of America. Testing, managing, and treating hepatitis C. Available at: http://www.hcvguidelines.org. Updated December 19, 2023. Accessed on October 24, 2025.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	12/14/2023
Annual Revision	No criteria changes.	12/17/2024
Update	Date: 06/26/2025 No criteria changes. Policy Overview updated to reflect new indication.	06/26/2025

Annual Revision	No criteria changes.	11/05/2025