

A Modifiable Barrier to Hepatitis C Virus Elimination in Rhode Island: The Prior Authorization Process for Direct-Acting Antiviral Agents

PATRICK DURYEA, BA; JACKIE HABCHI, PharmD; SOPHIE SPRECHT-WALSH, LPN;
AURIELLE THOMAS, MSc; JEFFREY BRATBERG, PharmD

ABSTRACT

Hepatitis C virus (HCV) is disproportionately prevalent among different groups of marginalized populations in Rhode Island (RI). Although direct-acting antiviral (DAA) agents are safe and cure HCV, RI payers limit access to these life-saving medications using prior authorizations (PAs). We assessed RI DAA-specific PA criteria. The authors reviewed payers' websites and/or called payers to obtain, describe, and analyze DAA PA forms, and approval and appeal processes. While some information was consistently required, we observed substantial differences among payers' requirements. All PA forms require at least one piece of data that is clinically superfluous for DAA prescription. These include post-treatment laboratory results, prescriber requirements, documentation of co-treatment of substance use disorders, and repeat diagnostic tests. Post-approval barriers also exist; DAA PAs are time-limited, and DAAs can only be obtained from preferred pharmacies. The PA process requires many steps, differing across RI payers, taking 45–120 minutes per patient. To achieve HCV elimination, DAA PA forms and processes should be standardized, streamlined, and ultimately removed.

KEYWORDS: hepatitis C virus (HCV), prior authorization (PA), direct-acting antiviral (DAA), people who inject drugs (PWID)

INTRODUCTION

Hepatitis C virus (HCV) is the most common bloodborne infection in the U.S.¹ HCV incidence is rising dramatically, driven by percutaneous transmission among younger people who inject drugs (PWID).² These data along with the benefits of treatment contributed to Centers for Disease Control and Prevention and U.S. Preventive Services Task Force recommendations for universal testing of all adults.^{3,4}

Oral direct-acting antivirals (DAAs) are safe and effective curative therapies for HCV. Contemporary short-term formulations are typically pan-genotypic and taken once daily. Although prices of DAAs have decreased, and treatment leading to cure is cost-saving and cost-effective, many DAAs remain in a tier of higher-priced medications with access

regulated by private and public payers through specialty pharmacies-only access and prior authorization (PA) processes.^{5,6} Acquiring DAAs for a patient requires clinical and administrative teams (e.g. physicians, nurses, pharmacists) and then patients to navigate complex PA processes that differ for every payer in Rhode Island (RI).

DAA PAs are paper or electronic forms that require patient-specific demographic, medical and non-medical information, plus supporting laboratory results. Typically, a physician evaluates a patient and chooses to prescribe the best DAAs for that specific patient. A payer-specific PA request form must be submitted, reviewed, and approved before the patient can obtain DAAs. There are myriad reasons for PA denials, ranging from a request for a regimen that is not on the payer-specific preferred drug formulary, to missing a non-essential piece of information (see Case Examples). PA re-submissions require providing data rebutting the denial, and often patient-specific provider letters. If the payer still denies the PA, the prescriber must contact the payer to conduct a peer-to-peer appeal, which can involve weeks of correspondence via phone voicemail. Once approved, the payer will only approve the treatment until a specific date. If a refill is needed or treatment is initiated after the PA expires, the PA must be redone, even if treatment has already started.

For patients to physically receive their medication, each payer requires that DAAs be obtained exclusively via a payer-specific preferred specialty pharmacy. Specialty pharmacies are either local, with a walk-in location, or central, which deliver medications by mail. Most payers will not notify the pharmacy of the prescription approval, so prescribers often must call in prescriptions. Patients are provided with a 1-month supply of medications and must call the pharmacy for refills for a 2-, 3- or 6-month regimen. Patients that are new to the specialty pharmacy must create a profile over the phone and receive counseling by the payer's preferred pharmacist, about their DAA regimen. A significant burden of HCV lies with PWID and people who are homeless-experienced.⁷ The challenges of limited access to consistent housing, transportation, and phones, underscore the difficulties of the PA process for certain sub-populations and their prescribers. Our objective was to describe the RI DAA PA process.

METHODS

We evaluated RI payer PA criteria for DAA approval. We identified 12 different RI DAA PAs: six Medicaid, four Medicare, and two Commercial. We selected a representative sample of six payers: three public (Medicaid: UnitedHealthcare of RI (UHC), Tufts Health Plan of RI, Neighborhood Health Plan of RI), two private (Blue Cross Blue Shield of RI (BCBS), Aetna of RI), and the AIDS Drug Assistance Program (ADAP) of RI for Human Immunodeficiency Virus (HIV)/HCV co-infected patients. We focused on three Medicaid payers because their covered patients possess a higher prevalence of HCV than payers that cover non-Medicaid recipients.⁸ We examined two private insurers and one drug assistance program to broaden the scope of this investigation and better understand PAs across different types of RI payers. We searched the payers' websites between January 10 and March 11, 2020 to find PA request forms that must be submitted for consideration of DAA approval.

One author contacted payers by email, to verify that the information on the online PA request forms used for the PA request process were up to date. When payers did not respond to emails, authors called the payer's public patient and provider phone number. Of the six payers, four responded to the verification request. No edits to the PA process were obtained. Two authors extracted data from payer-specific PA request forms into a standardized spreadsheet. One co-author verified the data. Outcome variables consisted of clinical and non-clinical features of each payer's PAs. Data used for outcome variables was publicly available. The verified processes from each payer were assessed for discrepancies between requirements of the PA request forms and the current evidence-based society guidelines (HCVguidelines.org).⁹

RESULTS

(Table 1) All payers require the following information be submitted: HCV genotype, HCV ribonucleic acid (RNA) viral load (VL), estimate of liver fibrosis stage, the test used to estimate fibrosis stage, and cirrhosis status. Four payers require an

HCV RNA VL result within 90 days of the PA request (even for patients with years of documented HCV viremia). Three payers required a prescriber to agree to submit patients' 12-week post-treatment HCV RNA VL sustained virologic response (SVR) result (signifying whether the patient achieved cure) back to the payer. One payer requires an HCV genotype within 90 days of the PA request (even for patients with years of the same documented genotype without risk for reinfection with a new genotype). Five payers require the prescriber's medical specialist status or preferred provider status. ADAP requires that patients with substance use disorders (SUDs) sign an agreement and participate in a clinician-monitored treatment program or be abstinent for six months prior to HCV treatment initiation (documented by attestation). Three payers require information about transplant history, two require HIV status, two require ethnicity,

Table 1. Summary of Prior Authorizations for Direct-Acting Antivirals in Rhode Island

Plan	Rhode Island Public Payers				RI Private Payers	
	UHC*	THP*	NHP*	ADAP*	BCBS*	Aetna*
	Community	RItogether	Medicaid			
		CVS		RIH	Prime	
Preferred pharmacy	BriovaRx	Caremark ¹	Walgreens ²	Pharmacy ³	Therapeutics	None
Preferred pharmacy type	Central	Central	Local	Local	Central	None
Prescriber information	√	√	√	√	√	√
Prescriber specialist status	√	√	√		√	√
Preferred Provider status	√	√ ⁴	√ ⁵	√ ⁵		
Agreement to submit post-treatment VL ⁶	√	√		√		√
Treatment start date			√	√		√
Fibrosis stage (0-4) & test used to estimate	√	√	√	√	√	√
Cirrhosis & compensation status	√	√	√	√	√	√
APRI ⁷ & Fibrosure					√ ⁸	
HCV Genotype	√ ⁹	√	√	√	√	√
HCV VL within 90 days of PA request	√	√	√	√		
Date of HCV VL	√	√	√	√		√
HCV VL "most recent"					√	
HCV VL within 6 months of PA request						√
Patient address	√				√	√
Patient ethnicity		√			√	
Patient weight					√	√
Patient contract				√ ¹⁰		
Patient substance use treatment				√ ¹¹		

* United Healthcare of RI (UHC), Tufts Health Plan of RI (THP), Neighborhood Health Plan of RI (NHP), Blue Cross Blue Shield of RI (BCBS), Aetna of RI, AIDS Drug Assistance Program of RI (ADAP)

¹ CVS Caremark Central is their preferred pharmacy. Also, CVS Local Specialty can help in answering questions.

² 335 Prairie Ave, Providence RI (Local Specialty)

³ 593 Eddy Street, Providence RI or medication transferred to The Miriam Hospital (164 Summit Ave., Providence RI).

⁴ If a patient's hepatic fibrosis stage is F3 or F4, the submitting prescriber "must be on the Rhode Island Medicaid Hepatitis C Preferred Provider List" or in co-managing the patient with a Preferred Provider.

⁵ Prescriber is required to be enrolled as a Preferred Provider.

⁶ Viral load

⁷ Aspartate Aminotransferase to Platelet Ratio Index

⁸ Both APRI and Fibrosure are required.

⁹ HCV Genotype within 90 days of PA request

¹⁰ The patient must sign a contract before starting treatment. ADAP's sample contract states that nonadherence will result in nonrenewal of medications, among other things. The suggested contract is meant to be stored in patient's medical record, and not used for eligibility.

¹¹ Patients with alcohol or drug misuse must be participating in a clinician-monitored treatment program or substance-free for six months. Treatment and monitoring may be documented by attestation.

and two require weight. None had PA processes that were the same or followed standardized formatting. The complete DAA PA process from prescription to DAA acquisition took 45-120 minutes per patient, longer with a protracted denial and appeals process.

Payers' preferred pharmacy is the only option for patients to obtain DAAs. BriovaRx, UHC's preferred pharmacy, requires the medication be shipped to a patient's address. BriovaRx staff will not call the prescriber if a patient cannot be reached via telephone. If BriovaRx requires additional documentation or if a PA must be redone, the pharmacy will only use fax, and will not reach out to the prescriber. This may take several hours to multiple days.

Case Example 1

A patient presented with HCV genotype 2 and compensated cirrhosis in 2015. He was evaluated and prescribed a 16-week therapy with sofosbuvir and daclatasvir in accordance with society guidelines at the time (HCVguidelines.org).⁹ Medicaid denied the PA multiple times. The patient was eventually granted approval for a shorter therapy of 12 weeks despite his physician's explanation that the data supported a 16-week course. This patient did not achieve SVR despite reporting perfect adherence. His physician then prescribed a second regimen, this time requiring 24 weeks of DAAs. While he achieved SVR with this second regimen, his SVR was delayed, with an inflated cost for cure with two DAA regimens over 36 weeks. Following SVR, the patient was diagnosed with hepatocellular carcinoma (HCC). Chronic HCV infection is the leading cause of HCC in the U.S., while SVR reduces the risk for developing HCC.

Case Example 2

A patient presenting with HCV in 2018 was approved for an 8-week regimen. Due to complex life challenges, the patient did not retrieve DAAs from the pharmacy nor initiate treatment. In 2020, this patient requested treatment with the same physician, who completed a new PA. The PA was denied, stating that documentation of prior HCV treatment must be provided, even though the PA indicated no prior treatment. This denial was appealed on three separate occasions but no response from the payer has been received.

DISCUSSION

We evaluated the DAA PA process for six RI payers. The process entails several time-consuming administrative steps, including phone calls, faxes, and peer-to-peer clinical discourse. For PAs in general, beyond HCV antiviral therapy, U.S. physicians report spending an average of 14.9 hours per week, and 91% of physicians report delays to necessary care because of the time to complete PAs.¹⁰ Thirty-six percent of physicians have staff exclusively working on PAs.¹⁰ In one HCV-specific study, although one-quarter of patients were

denied initial DAA approval, most prescriptions eventually were approved. Initial denials are often not medically justified and may serve as a deterrent.¹¹

Several DAA PA requirements across multiple payers are gratuitous. These include an HCV RNA VL result within 90 days of the PA request, specialty or preferred provider status, submission of post-treatment VL results, and treatment and monitoring of SUDs. Four payers require an HCV RNA VL or genotype result within 90 days of the PA request. Patients with years of documented viremia and recent genotyping, prescribed pan-genotypic regimens, are still forced to undergo inconvenient, costly, and redundant laboratory tests. Current evidence-based guidelines call for one HCV RNA VL any time before treatment initiation (HCVguidelines.org).⁹

No policy restricts non-specialists or non-preferred providers from prescribing DAAs in RI, yet all payers require prescribers to state their specialty and/or status as a preferred provider. No differences in efficacy were found for non-specialist providers administering HCV treatment compared to specialist providers.¹² Non-specialist or non-preferred providers may be confused by this inconsistency, potentially dissuading them from prescribing DAAs, discouraging the patient from seeking treatment, or leading to a referral to yet another physician who is considered a specialist or preferred provider. Each of these outcomes increases the potential for delayed treatment and cure. This may prolong the time of infectivity, contribute to patients dropping out of HCV care or being lost to follow-up, and impact morbidity and mortality.

Four payers also require DAA prescribers to agree to submit a post-treatment HCV RNA VL (SVR result), back to the payer. Physicians are not obligated to provide treatment outcomes to payers for other diseases; this is particular to HCV. For example, prescribers do not have to provide back to payers non-detectable HIV VL data for antiretroviral prescriptions, nor hemoglobin A1C data for diabetes medications. Sharing patient's SVR data with payers is unwarranted.

Other PA requirements impede HCV cure. ADAP requests that patients with SUDs sign a contract, as well as participate in a clinician-monitored treatment program or demonstrate six months of pre-treatment abstinence. A large body of evidence demonstrates that DAA treatment in people with SUDs leads to SVR rates comparable to those without SUDs and that there is not justification for pre-treatment sobriety.^{9,13-14} Also, a patient's weight and ethnicity are unnecessary for DAA prescription.

Non-invasive assessments of liver fibrosis estimate the presence of advanced fibrosis. Non-invasive markers do not precisely differentiate Meta-Analysis of Histologic Data in Viral Hepatitis (METAVIR) fibrosis stage (F) F0-F3. What is necessary for selecting a DAA regimen is knowledge of whether the patient has cirrhosis or not, and whether cirrhotic patients are decompensated or not. This is highly dependent on clinical presentation and clinical diagnosis. BCBS of RI requires both aspartate aminotransferase to platelet ratio index (APRI) and

a high-priced Fibrosure test for DAA approval (even for young patients with incident infection without fibrosis). Additionally, the PA forms may encourage prescribers to order elastography when it is not medically indicated or to assume that elastography is a requirement for prescribing antiviral therapy.

Even after PA approval, care teams and patients face access and communication hurdles. UHC's preferred pharmacy, BriovaRx, requires a patient's address to ship approved medications, and does not follow up with patients when delivery concerns arise. These requirements hinder treatment for homeless adults, of whom approximately 44% are HCV-infected.¹⁵ BriovaRx's limited contact options and poor communication further diverts staff time away from navigating patients to cure.

States should collaborate on system-level strategies to reduce barriers to care, such as PAs, to advance U.S. HCV elimination goals.¹⁶ Some states, such as Washington, have successfully removed PAs for DAAs for most eligible patients prescribed glecaprevir/pibrentasvir.¹⁷

CONCLUSION

In RI, HCV elimination has been impeded in part due to the time-intensive, multi-step DAA PA process, differing across payers. Delaying HCV elimination, especially in the transmitting population, increases risks to the community, and increases costs to detect, treat, and monitor more people. Action from legislators and healthcare officials is indicated. PAs for DAAs should be standardized, streamlined or removed to increase access to safe, efficacious, and cost-effective medications.

References

1. Lanini S, Ustianowski A, Pisapia R, Zumla A, Ippolito G. Viral Hepatitis: Etiology, Epidemiology, Transmission, Diagnostics, Treatment, and Prevention. *Infect Dis Clin North Am.* 2019;33(4):1045-1062.
2. Ryerson AB, Schillie S, Barker LK, Kupronis BA, Wester C. Vital Signs: Newly Reported Acute and Chronic Hepatitis C Cases - United States, 2009-2018. *MMWR Morb Mortal Wkly Rep.* 2020;69(14):399-404.
3. US Preventive Services Task Force, Owens DK, Davidson KW, et al. Screening for Hepatitis C Virus Infection in Adolescents and Adults: US Preventive Services Task Force Recommendation Statement. *JAMA.* 2020;323(10):970-975.
4. Schillie S, Wester C, Osborne M, Wesolowski L, Ryerson AB. CDC Recommendations for Hepatitis C Screening Among Adults - United States, 2020. *MMWR Recomm Rep* 2020;69[No. RR-2]:1-17.
5. Linas BP, Nolen S. A Guide to the Economics of Hepatitis C Virus Cure in 2017. *Infect Dis Clin North Am.* 2018;32(2):447-459.
6. Trooskin SB, Reynolds H, Kostman JR. Access to Costly New Hepatitis C Drugs: Medicine, Money, and Advocacy. *Clin Infect Dis.* 2015;61(12):1825-1830.
7. Aisyah, DN, Shallcross, L, Hayward, A, et al. Hepatitis C among vulnerable populations: A seroprevalence study of homeless, people who inject drugs and prisoners in London. *J Viral Hepat.* 2018; 25: 1260-1269.

8. Johnson RL, Blumen HE, Ferro C. The burden of hepatitis C virus disease in commercial and managed Medicaid populations. The California Hepatitis C Task Force Web site. <http://www.californiahcvtaskforce.org/pdf/milliman-hcv-burden.pdf>. July 8, 2015. Accessed April 21, 2020.
9. IDSA-AASLD HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C. <https://www.hcvguidelines.org/>. Accessed April 14, 2020.
10. 2018 American Medical Association (AMA) Prior Authorization Physician Survey. AMA Web site. <https://www.ama-assn.org/system/files/2019-02/prior-auth-2018.pdf>. Accessed March 9, 2020.
11. Do A, Mittal Y, Liapakis A, et al. Drug authorization for sofosbuvir/ledipasvir (Harvoni) for chronic HCV infection in a real-world cohort: a new barrier in the HCV care cascade. *PLoS One.* 2015;10(8):e0135645.
12. Kattakuzhy S, Gross C, Emmanuel B, et al. Expansion of treatment for hepatitis C virus infection by task shifting to community-based nonspecialist providers: a nonrandomized clinical trial. *Ann Intern Med.* 2017;167(5):311-318.
13. Graf C, Mücke MM, Peiffer KH, et al. Efficacy of Direct-acting Antivirals for Chronic Hepatitis C Virus Infection in People Who Inject Drugs or Receive Opioid Substitution Therapy: A Systematic Review and Meta-analysis. *Clin Infect Dis.* 2019 Sep 12. [Epub ahead of print].
14. Norton BL, Fleming J, Bachhuber MA, et al. High HCV cure rates for people who use drugs treated with direct acting antiviral therapy at an urban primary care clinic. *Int J of Drug Pol.* 2017;47:196-201.
15. Barocas JA, Beiser M, León C, Gaeta JM, O'Connell JJ, Linas BP. Experience and Outcomes of Hepatitis C Treatment in a Cohort of Homeless and Marginally Housed Adults. *JAMA Intern Med.* 2017;177(6):880-882.
16. World Health Organization. Combating Hepatitis B and C to reach elimination by 2030. https://apps.who.int/iris/bitstream/handle/10665/206453/WHO_HIV_2016.04_eng.pdf;jsessionid=6F79DCFF6C264CF4747512CC59ED4ADC?sequence=1. May 2016. Accessed April 14, 2020.
17. Washington State Health Care Authority, Washington State Department of Health. Hepatitis C Medications: Comprehensive Purchasing Strategies. <https://www.hca.wa.gov/assets/program/hepatitis-c-medications-20191126.pdf>. Accessed April 14, 2020.

Acknowledgment

The authors would like to thank the many patients with HCV who worked through the prior authorization process. This work was supported in part by the University of Rhode Island, College of Pharmacy Healthcare Research Operating Fund.

Authors

Patrick Duryea, BA, University of Rhode Island, Providence, RI.
 Jackie Habchi, PharmD, CODAC Behavioral Healthcare, Providence, RI.
 Sophie Sprecht-Walsh, LPN, CODAC Behavioral Healthcare, Providence, RI.
 Aurielle M. Thomas, MSc, University of Rhode Island, Providence, RI.
 Jeffrey Bratberg, PharmD, University of Rhode Island, Providence, RI.

Correspondence

Patrick Duryea, BA, Research Assistant
 University of Rhode Island
 80 Washington Street, Room 528, Providence, RI 02903
 401-277-5004
pduryea@uri.edu