

Health Equity Coverage Recommendation Form

Title:	Health Equity in Hepatitis
Date of Last Review:	12/1/25

Research Section

Background

According to the [World Health Organization](#) hepatitis is an inflammation of the liver that is caused by both infectious viruses and noninfectious agents.¹ There are five main strains of the hepatitis virus, referred to as types A, B, C, D and E. While all of these forms of hepatitis can cause liver disease, they differ in important ways including modes of transmission, severity of the illness, geographical distribution, and prevention methods. Types B and C in particular can lead to chronic disease and together are the most common cause of liver cirrhosis, liver cancer, and viral hepatitis-related deaths.

Inequities discussed on the [Office of Minority Health Website](#)²

[Hepatitis and American Indians/Alaska Natives](#)³

- American Indians/Alaska Natives have historically had the highest rates for Hepatitis A prior to 1995, although these numbers have decreased dramatically
- American Indians/Alaska Natives are twice as likely to die from viral hepatitis when compared to non-Hispanic white Americans (and 2.7 times more likely to die from hepatitis C than non-Hispanic white Americans).

[Hepatitis and Hispanic/Latino Americans](#)⁴

- In 2017, Hispanic Americans were 70% more likely to die from viral hepatitis as compared to non-Hispanic white Americans.
- Despite having lower case rates of hepatitis C, Hispanic Americans were 40% more likely to die from the disease than non-Hispanic white Americans in 2018.

[Hepatitis and Asian Americans](#)⁵

- In the U.S., approximately half of the one million persons with chronic hepatitis B virus (HBV) infections are Asian/Pacific Islanders, most of whom became infected before arriving to the country.
- Asian Americans were twice as likely to develop chronic hepatitis B, as compared to white Americans, from 2013-2016
- In 2018, Asian Americans were almost eight times more likely to die from hepatitis B than non-Hispanic white Americans.

Review of current, peer-reviewed evidence from established sources

There were no studies identified that discuss ethnic/minority populations in the United States that experience hepatitis.

Review of clinical practices guidelines from professional associations and societies in regard to these findings

American Association for the Study of Liver Diseases (AASLD) /Infections Diseases Society of America (IDSA):

In 2023, the American Association for the Study of Liver Diseases and the Infections Diseases Society of America HCV Guidance Panel published an updated [guidelines](#) for the diagnosis, management, and treatment of Hepatitis C virus (HCV) infections. The panel emphasized the following:⁶

- Universal HCV screening
- New recommendations that address the management of incomplete treatment adherence;
- Updated recommendations regarding simplified treatment with minimal monitoring and expanded eligibility;
- Management and treatment recommendations for solid organ transplant recipients;
- Newly expanded treatment and retreatment recommendations for children and adolescents;
- Screening, management, and treatment recommendations for unique and key populations (HIV/HCV-coinfected persons, people who inject drugs (PWID), men who have sex with men (MSM), and incarcerated persons).

Centers for Disease Control and Prevention (CDC):

Hepatitis B

In 2023, the CDC published updated [recommendations](#) for hepatitis B virus (HBV) screening and testing, expanding on the recommendations published in 2008. The recommendations state:⁷

- Screen all adults 18 years and older at least once in their lifetime using a triple panel test
- Screen pregnant people for hepatitis B surface antigen (HBsAg) during each pregnancy regardless of vaccination status and history of testing
- Expand periodic risk-based testing to include people who are incarcerated, people with a history of sexually transmitted infections or multiple sex partners, and people with hepatitis C virus infection

- Test anyone who requests HBV testing regardless of disclosure of risk

In 2022, the CDC published [recommendations](#) for hepatitis B vaccinations:⁸

- HepB vaccination is recommended for adults aged 19-59 years and adults aged ≥ 60 years with risk factors for hepatitis B.
- Adults aged ≥ 60 years without know risk factors for hepatitis B may also receive HepB vaccines
- Infants and all other persons aged < 19 years are already recommended to receive HepB vaccines

Hepatitis C

In 2020, the CDC published [recommendations](#) for hepatitis c virus (HCV) screening among adults. The recommendations state:⁹

- All adults aged ≥ 18 years once in their lifetime
- Screening of all pregnant women (regardless of age) during each pregnancy
- Those with ongoing risk factors should be tested regardless of age or setting prevalence, including continued periodic testing as long as risks persist

*The recommendations include an exception for settings where the prevalence of HCV infection is demonstrated to be <0.1%.

Do any of these findings relate to any of our current policies?

None of the above findings are applicable to any of our current medical policies at this time.

Summary:

Medical Policy

Hepatitis disproportionately affects minority populations in the United States. Hispanic Americans are 70 percent more likely to die from viral hepatitis as their white adult counterparts. Asian Americans are eight times as likely to die from viral hepatitis when compared to non-Hispanic white Americans, and American Indians/Alaska Natives are twice as likely. Despite these discrepancies, evidence-based clinical practice guidelines state that optimal approaches for reducing infection/chronic infection in high-risk populations are unclear. Possible reasons for the higher incidence and mortality rates of hepatitis infections include access to medical care/screening and adherence to treatment plan. However, there remains no specific recommendations to guide care and reduce gaps in these minority populations. For this reason, there are no distinct utilization and medical necessity criteria for vulnerable populations regarding prevention, treatment, and management of hepatitis infected individuals at this time.

Pharmacy Policy

To improve health equity from a pharmacy payor perspective, reducing barriers and improving access to care is vital^{10,11,12}. Many medications used for the treatment of hepatitis, including Pegasys, lamivudine, entecavir, tenofovir, and ribavirin, are available on all formularies without prior authorization. The medications that do require prior authorization include the hepatitis C direct-acting antivirals. Of note, the preferred therapies (generic Epclusa® and Mavyret® tablet) do not require prior authorization for Medicaid members if they are treatment naïve. While prior authorization is a barrier to care, the direct acting antivirals are very high-cost specialty medications that require extra monitoring, and appropriate use is important to reduce the incidence of resistance. The prior authorization policies align with guideline recommendations, FDA labeling, and clinical trial study designs to ensure the medications are being reserved for patients who will benefit most from therapy. Requiring specialty drugs to be dispensed through specialty pharmacy allows them to have additional monitoring by clinical pharmacists for adherence and side effects. Many of these therapies have patient assistance programs available through the manufacturer. The copay for specialty drugs depends on the member’s benefit. For the Commercial line of business, it often depends on the company the patient works for and what kind of benefits are offered to the employees.

A formulary placement review was completed for all applicable medications used for the treatment of hepatitis, to identify opportunities to reduce cost and therefore improve access and adherence for our members. Based on this review, the decision was made to move both strengths of entecavir tablets from the non-preferred tier 4 to the lower cost share tier 2.

Vaccinations used for the prevention of hepatitis A and B are covered without prior authorization, in alignment with recommendations put out by the Centers for Disease Control and Prevention (CDC) recommendations and recommendations by the Advisory Committee for Immunization Practices (ACIP).

PHP also offers mail-order, which helps to improve access and adherence to medications. For some groups, individuals can receive a 90-day supply at a reduced cost-share when ordering medications through mail order.

Recommendation:	A formulary placement review was completed for all applicable medications used for the treatment of hepatitis, to identify opportunities to reduce cost and therefore improve access and adherence for our members. Based on this review, the decision was made to move both strengths of entecavir tablets from the non-preferred tier 4 to the lower cost share tier 2.
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CORE Revision History Section

DATE	SUMMARY OF CHANGES
11/13/2023	Initial review.
11/24/2024	Annual update. No changes.

Disclaimer: Providence Health Plan (PHP) and Providence Health Assurance (PHA) CORE forms serve as guidance for the administration of plan benefits. CORE forms do not constitute medical advice nor a guarantee of coverage. PHP and PHA CORE Medical Policy forms are based upon CMS guidelines and published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last CORE update. PHP and PHA CORE Coding Policy forms are based on national coding standards and CMS guidelines. PHP and PHA reserve the right to determine the application of CORE forms and make revisions to its CORE forms at any time.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and PHP and PHA CORE forms will be resolved in favor of the coverage agreement.

11/20/2025

Annual review. No changes to recommendations. No new evidence identified.
Updates to pharmacy tiering

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