

UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1231-11
Program	Prior Authorization/Notification
Medication	Mavyret® (glecaprevir/pibrentasvir)
P&T Approval Date	9/2017, 11/2018, 11/2019, 3/2020, 3/2021, 8/2021, 8/2022, 8/2023, 8/2024, 7/2025, 10/2025
Effective Date	1/1/2026

1. Background:

Mavyret is a fixed-dose combination of glecaprevir, a hepatitis C virus (HCV) NS3/4A protease inhibitor, and pibrentasvir, an HCV NS5A inhibitor, and is indicated for the treatment of adult and pediatric patients 3 years and older with acute or chronic HCV genotype (GT) 1, 2, 3, 4, 5 or 6 infection without cirrhosis and with compensated cirrhosis (Child-Pugh A). Mavyret is also indicated for the treatment of adult and pediatric patients 3 years and older with HCV genotype 1 infection, who previously have been treated with a regimen containing an HCV NS5A inhibitor or an NS3/4A protease inhibitor, but not both.

2. Coverage Criteria^a:

<p>A. For the treatment of acute hepatitis C infection in treatment-naïve patients, Mavyret will be approved based on all of the following criteria:</p> <ol style="list-style-type: none"> 1. Diagnosis of acute hepatitis C infection <p style="text-align: center;">-AND-</p> <ol style="list-style-type: none"> 2. Patient is treatment-naïve <p style="text-align: center;">-AND-</p> <ol style="list-style-type: none"> 3. Patient is not receiving Mavyret in combination with another hepatitis C virus (HCV) direct acting antiviral agent [e.g., Epclusa (sofosbuvir/velpatasvir), Harvoni (ledipasvir/sofosbuvir), Sovaldi (sofosbuvir), Zepatier (elbasvir/grazoprevir)] <p>Authorization will be issued for 8 weeks.</p> <p>B. For the treatment of chronic hepatitis C infection, Mavyret will be approved based on both of the following criteria:</p> <ol style="list-style-type: none"> 1. Diagnosis of chronic hepatitis C infection <p style="text-align: center;">-AND-</p> <ol style="list-style-type: none"> 2. Patient is not receiving Mavyret in combination with another HCV direct acting antiviral agent [e.g., Epclusa (sofosbuvir/velpatasvir), Harvoni (ledipasvir/sofosbuvir), Sovaldi

(sofosbuvir), Zepatier (elbasvir/grazoprevir)]

Authorization will be issued for 12 months.

^a State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place
- Medical necessity may be in place.

4. References:

1. Mavyret [package insert]. North Chicago, IL: AbbVie Inc.; June 2025.
2. American Association for the Study of Liver Diseases and the Infectious Diseases Society of America. Recommendations for Testing, Managing, and Treating Hepatitis C. Accessed September 5, 2025.

Program	Prior Authorization/Notification – Mavyret (glecaprevir/pibrentasvir)
Change Control	
Date	Change
9/2017	New program.
11/2018	Annual review with no changes to clinical criteria. Updated references.
11/2019	Annual review. Updated treatment duration for treatment naïve patients with cirrhosis based on updated labeling. Updated background and references.
3/2020	Updated criteria to include treatment for liver and kidney transplant recipients. Updated background and references.
3/2021	Annual review with no changes to clinical criteria. Updated references.
8/2021	Updated background with no changes to clinical criteria. Updated references.
8/2022	Annual review. Updated coverage criteria for liver or kidney transplant recipients per prescribing information. Updated references.
8/2023	Annual review with no changes to coverage criteria.
8/2024	Annual review with no changes to coverage criteria. Updated references.
7/2025	Updated coverage criteria for acute HCV infection per prescribing information. Updated references.
10/2025	Reorganized criteria so that chronic HCV infection for treatment-experienced patients as well as liver and kidney transplant recipients are addressed in one section. Simplified pangenotypic treatment and

	cirrhosis status criteria. Updated authorization to 12 months. Updated references.
--	------------------------------------------------------------------------------------