Reference number(s)
2901-A

SPECIALTY GUIDELINE MANAGEMENT

VEMLIDY (tenofovir alafenamide)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications
Treatment of chronic hepatitis B virus (HBV) infection in adults with compensated liver disease

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Chronic hepatitis B virus infection
Authorization of 6 months may be granted for treatment of chronic hepatitis B virus (HBV) when the member is HIV-1 negative.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Vemlidy [package insert]. Foster City, CA: Gilead Sciences, Inc.; February 2019.

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