

## **Clinical Policy: Tenofovir Alafenamide Fumarate (Vemlidy)**

Reference Number: CP.CPA.363

Effective Date: 09.01.25

Last Review Date: 11.25

Line of Business: Commercial\*

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Tenofovir alafenamide fumarate (Vemlidy<sup>®</sup>) is a hepatitis B virus (HBV) nucleoside analog reverse transcriptase inhibitor.

*\* California Exchange Plans should not be approved using these criteria; for California Exchange Plans refer to the CP.PMN.268 Tenofovir Alafenamide Fumarate (Vemlidy) criteria*

### **FDA Approved Indication(s)**

Vemlidy is indicated for the treatment of chronic HBV infection in adults and pediatric patients 6 years of age and older and weighing at least 25 kg with compensated liver disease.

### **Policy/Criteria**

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Vemlidy is **medically necessary** when the following criteria are met:

#### **I. Initial Approval Criteria**

##### **A. Hepatitis B Virus Infection (must meet all):**

1. Diagnosis of chronic HBV infection;
2. Prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease specialist;
3. Age  $\geq$  6 years and weight  $\geq$  25 kg;
4. Dose does not exceed both of the following (a and b):
  - a. 25 mg per day;
  - b. 1 tablet per day.

**Approval duration: 12 months or duration of request, whichever is less**

##### **B. Other diagnoses/indications (must meet 1 or 2):**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial; or

- b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial.

## II. Continued Therapy

### A. Hepatitis B Virus Infection (must meet all):

1. Member meets one of the following (a or b):
  - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
  - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed both of the following (a and b):
  - a. 25 mg per day;
  - b. 1 tablet per day.

**Approval duration: 12 months or duration of request, whichever is less**

### B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial.

## III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off-label use policies – CP.CPA.09 for commercial.

## IV. Appendices/General Information

*Appendix A: Abbreviation/Acronym Key*

FDA: Food and Drug Administration

HBV: hepatitis B virus

*Appendix B: Therapeutic Alternatives*  
Not applicable

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s): none reported
- Boxed warning(s): post treatment severe acute exacerbation of hepatitis B

*Appendix D: General Information*

- In April of 2017, the FDA removed Vemlidy’s boxed warning regarding lactic acidosis and severe hepatomegaly with steatosis.

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
HBV infection	25 mg PO QD	25 mg/day

**VI. Product Availability**

Tablet: 25 mg

**VII. References**

1. Vemlidy Prescribing Information. Foster City, CA: Gilead Sciences; March 2024. Available at [https://www.gilead.com/-/media/files/pdfs/medicines/liver-disease/vemlidy/vemlidy\\_pi.pdf](https://www.gilead.com/-/media/files/pdfs/medicines/liver-disease/vemlidy/vemlidy_pi.pdf). Accessed August 11, 2025.
2. Terrault NA, Lok ASF, McMahon BJ, et al. Update on prevention, diagnosis, and treatment of chronic hepatitis B: AASLD 2018 hepatitis B guidance. *Hepatology*. 2018; 67(4): 1560-1599.
3. Guidelines for the prevention, diagnosis, care, and treatment for people with chronic hepatitis B infection. World Health Organization (WHO). 2024. Available at: <https://www.who.int/publications/i/item/9789240090903>. Accessed August 11, 2025.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created (adopted from CP.PMN.268) based on previously approved clinical guidance and June SDC decision; added the following clarification under the description section: California Exchange Plans should not be approved using these criteria; for California Exchange Plans refer to the CP.PMN.268 Tenofovir Alafenamide Fumarate (Vemlidy) criteria.	06.10.25	08.25
4Q 2025 annual review: no significant changes; references reviewed and updated.	08.11.25	11.25

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional

organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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