

## HEPATITIS C THERAPY PRIOR AUTHORIZATION FORM

*Incomplete forms will be returned*

**Please attach copies of the patient's medical history summary, lab and genetic test reports, and signed  
treatment agreement form(optional) and treatment plan.**  
**\*\*Please review our clinical criteria before submitting this form. \*\***

### Patient Information

Recipient: \_\_\_\_\_ MA#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Body Weight: \_\_\_\_\_ kg

### Treatment

If requesting a non-preferred treatment, please specify why preferred treatments are not appropriate

Mavyret (Preferred for all genotypes): Take \_\_\_\_\_ daily for \_\_\_\_\_ weeks

Sofosbuvir-Velpatasvir (Preferred for all genotypes): Take \_\_\_\_\_ daily for \_\_\_\_\_ weeks

Vosevi (Retreatment only): Take \_\_\_\_\_ daily for \_\_\_\_\_ weeks

Ledipasvir-Sofosbuvir (Preferred for genotype 1,4,5,6): Take \_\_\_\_\_ daily for \_\_\_\_\_ weeks

\_\_\_\_\_: Take \_\_\_\_\_ daily for \_\_\_\_\_ weeks

\_\_\_\_\_: Take \_\_\_\_\_ daily for \_\_\_\_\_ weeks

**Adherence with prescribed therapy is a condition for payment of therapy for up to the allowed timeframe for  
each HCV genotype.**

Has a treatment plan been developed and discussed with patient?  No  Yes

### Diagnosis

Acute Hep C  Chronic Hep C (Hep C present for  $\geq$  6 months as established by (please select one)  
 Lab testing such as an HCV antibody or HCV RNA test completed 6 months apart  
 HCV diagnosis documented in prescribers note from the past office visit(s)  
 Exposure risk history documented in prescribers notes from the past office visit(s)

Liver transplant recipient: Genotype of pre-transplant liver: \_\_\_\_\_  
Genotype of post-transplant liver: \_\_\_\_\_

Other: \_\_\_\_\_

What is the patient's HCV genotype and subtype? \_\_\_\_\_

Has a liver biopsy been performed?  No  Yes; Test date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Has a fibrosis test been performed:  No  Yes; Test used: \_\_\_\_\_; Test date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Metavir Grade: \_\_\_\_\_; Metavir Stage: \_\_\_\_\_

Child Pugh Score (required for treatment of some patients with cirrhosis): \_\_\_\_\_

What best describes this patient's liver disease? (Check all that apply):

No cirrhosis  Compensated cirrhosis  Decompensated liver disease

**\*\*Please provide a copy of the results of the biopsy, genotype, and any other fibrosis tests for  
this patient. \*\***

## Hepatitis C Treatment History

Has this patient been treated for Hepatitis C in the past:  Treatment Naive  Treatment Experienced

If Treatment Experienced, what was the outcome of the previous treatments:

Relapsed  Partial Responder  Non-Responder  Toxicities  Reinfection

Genotype pre-DAA therapy: \_\_\_\_\_ Genotype post-DAA therapy: \_\_\_\_\_

Please indicate what prior regimen(s) the patient has been treated with:

HCV regimen	Treatment duration/ dates	Treatment Outcome	
		<input type="checkbox"/> Relapsed	<input type="checkbox"/> Partial Responder
		<input type="checkbox"/> Non-Responder	<input type="checkbox"/> Toxicities
		<input type="checkbox"/> Reinfection	<input type="checkbox"/> Other: _____

### Laboratory Results

Recent baseline HCV RNA level (up to and including **180\* days prior**): \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**\*unless the patient is cirrhotic then the baseline lab values must be within 90 days of prior authorization request**

For cirrhotic patients please attach recent (within 90 days of PA request) total bilirubin, albumin, and INR

If a regimen is prescribed containing ribavirin, please attach recent hemoglobin, hematocrit, and platelet count.

### Medical History (Recent = 6 months prior to request for noncirrhotic or 3 months for cirrhotic patients)

Is the patient co-infected with HIV?  No  Yes; If yes, state the patient's recent HIV viral load? \_\_\_\_\_  
Date drawn: \_\_\_\_\_

Is the patient co-infected with HBV?  No  Yes; If yes, state the patient's recent HBV viral load? \_\_\_\_\_  
Date drawn: \_\_\_\_\_

Is the patient co-infected with other viral infection: \_\_\_\_\_

Has patient had a solid organ transplant?  No  Yes; If yes, specify what type of transplant: \_\_\_\_\_  
Date of transplant: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### Adherence Assistance

If the member needs assistance in order to successfully adhere to treatment, please explain what assistance is needed. If there are special instructions for contacting the member, please include. All members will be offered Case Management for Hepatitis C treatment. If member contact needs to go through provider office or pharmacy, please include. In order to determine lab and refill timeframes, please inform the Case Manager or MCO of actual treatment start date once member starts taking medication and please inform Case Manager or MCO if member discontinues treatment.

If the patient's Medicaid eligibility changes during therapy and the patient is no longer eligible for Medicaid prescription drug assistance, is the physician prepared to enroll the patient in other patient assistant drug programs to complete therapy?  Yes  No

**Contact Person at your office:** (name): \_\_\_\_\_ Telephone #: \_\_\_\_\_

**I certify that the benefits of the treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.**

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Prescriber's signature

Prescriber's Name

Date

Telephone# (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_ Fax# (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

Practice Specialty: \_\_\_\_\_

Address: \_\_\_\_\_