**BIOSCRIP PBM SERVICES/JAI MEDICAL SYSTEMS MANAGED CARE ORGANIZATION, INC.**
**Call Clinical Services Department at 1-800-555-8513 or Fax 1-800-583-6010. BioScrip will respond by fax or phone within 24 hours of receipt of this request.**

# HEPATITIS C THERAPY PRIOR AUTHORIZATION FORM

*Incomplete forms will be returned*

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

☐ ***Standard*** (Standard review timeframe is 2 business days for complete requests.)
☐ ***Urgent*** (Please only check this box if applying the standard review time frame may seriously jeopardize the member's life, health, or ability to regain maximum function. You must provide an explanation if box is checked.)

## Patient Information

Recipient:____________________________________________ MA#: ____________________________________________

Date of Birth: ________/________/________ Phone #: (     ) _______ - ________ Body Weight: ________ kg

## Treatment Plan

□ Sovaldi® (sofosbuvir) 400 mg: Take once daily for ________ weeks

□ Olysio® (simeprevir) 150 mg: Take once daily for ________ weeks

□ Harvoni®: Take________ tablet(s) once daily for ________ weeks

□ Viekira Pak™: Take as directed for ________ weeks

□ Ribavirin ________ mg: Take _______ in the morning and _______ in the afternoon for ______ weeks

□ Peginterferon alfa _____ mcg: Inject once weekly 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
Does the patient have any history of medication non-adherence? □ No □ Yes; If yes, please explain below:
_____________________________________________________________________________________________

## Diagnosis

□ Acute Hep C □ Chronic Hep C □ Hepatocellular Carcinoma

□ 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: ________

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

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

| HCV regimen | Treatment duration/dates | Treatment Outcome |
|---|---|---|
| | | □ Relapsed □ Partial Responder<br>□ Non-Responder □ Toxicities<br>□ Other: ______________________ |
| | | □ Relapsed □ Partial Responder<br>□ Non-Responder □ Toxicities<br>□ Other: ______________________ |

## Laboratory Results

Baseline HCV RNA level (within 90 days of treatment): ___________________________ Date: _______/________/________

Baseline AST: ________________________ Baseline ALT: ________________________ Date: _______/________/________

Baseline hemoglobin: __________________ Baseline hematocrit: ____________________ Date: _______/________/________

Baseline platelet: ________________________________ Date: ________/________/________

## Medical History

Is the patient co-infected with HIV? □ No □ Yes; If yes, state the patient's HIV viral load? __________________
Date drawn: ________________________________________________

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

## Substance Use History

Does the patient have an active diagnosis of a substance use disorder? □ Yes □ No

**If Yes**, is the patient actively engaged in treatment? □ Yes □ No;
**If No**, please indicate whether an adherence assessment has been done to assure successful treatment completion:
□ Yes □ No

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

**I certify that the information provided is accurate. Supporting documentation is available for State audits.**

______________________________________________________________________________

Prescriber's signature Prescriber's Name Date

Telephone# (______) – _____________- _________________ Fax# (_______) - _____________ - ________________

Practice Specialty: ______________________________________________________________________

Address: ______________________________________________________________________________