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

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 □ Non-Responder □ Toxicities □ Other: _____
		□ Relapsed □ Partial Responder □ Non-Responder □ Toxicities □ Other: _____

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 nonadherence? □ No □ Yes; If yes, please explain below:

_____
_____

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 a current diagnosis of a substance use disorder? □ No □ Yes

If yes, is the patient actively engaged in treatment? □ Yes □ No; If no, please state what substances are being used and how often:

_____

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: _____