UnitedHealthcare Community Plan

Hepatitis C Medications - Arizona
PRIOR AUTHORIZATION REQUEST FORM

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: _____
Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:	M.D./D.O.
Address:		City:	State: ZIP code:
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax attention to:			

Section C - Medical Information (***This form is for Hepatitis C Medications only; for all other drugs please submit a new form***)

Medication 1:	**Strength:**
Directions for use:	**Quality:**
Medication 2:	**Strength:**
Directions for use:	**Quality:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS WITH HEPATITIS C
All supporting labs and chart documentation is required for medical review of this request.

Genotype (Must submit supporting lab documentation)
□ Genotype 1 □ Genotype 2 □ Genotype 3 □ Genotype 4 □ Genotype 5 □ Genotype 6
□ Other Genotype (Must Specify): _____

Prescriber Specialty: **□ Hepatologist** **□ Gastroenterologist** **□ Infectious Disease Physician**
□ Other (Specify): _____

Has this patient been treated for Hepatitis C previously? □ Yes □ No
If "Yes", please provide details of previous therapy including names of medications used, dates of therapy, and outcome of treatment / reason for discontinuing: _____
_____

Section D – Previous Medication Trials

Trial	Regimen (*List all medications tried with each trial*)	Dates of Therapy	Treatment Complete	Outcome of Treatment or Reason for Discontinuation
1				
2				
3				

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Member Last Name:	Member First Name:	Date of Birth:

Clinical and Drug Specific Information

ALL REQUESTS	
The following information below MUST be included upon submission: □ Medication name, dose, and duration □ Relevant medical records with current medication list □ Laboratory results dated within the last 90 days □ Agreement to submit post-treatment viral load data if requested	
□ Yes □ No	**Does the patient have a diagnosis of chronic hepatitis C infection status which has been confirmed by detectable serum hepatitis C virus ribonucleic acid (HCV RNA) by quantitative assay completed within the past 90 days?** *If yes, list HCV RNA and date:*
□ Yes □ No	**Has patient readiness been assessed and patient attestation of compliance is submitted and on file in the patient's medical record?**
□ Yes □ No	**Does the patient agree to complete the regimen and understand risks of reinfection and other contributors to liver disease and/or damage, through a signed attestation?**
□ Yes □ No	**Does the prescriber clinician agree to maintain hepatitis C virus ribonucleic acid (HCV RNA) by quantitative assay test levels obtained at 12 & 24-weeks post therapy completion to demonstrate the Sustained Virologic Response (SVR)?**
□ Yes □ No	**Has the patient been screened for Hepatitis A and B and received at least one Hepatitis A and at least one Hepatitis B vaccine prior to requesting treatment, unless the patient demonstrates laboratory evidence of immunity?** *If yes, list vaccine or lab immunity test date:*
□ Yes □ No	**Has the patient had a substance use disorder in the past 12 months?**
□ Yes □ No	**Has the patient been in remission for the past three months?**
□ Yes □ No	**Is the patient engaged in a substance use disorder treatment program at the time of the prior authorization request, and over the course of treatment?**
□ Yes □ No	**Is the patient participating in a treatment adherence program?**
□ Yes □ No	**If the patient is prescribed ribavirin, will the provider monitor hemoglobin levels periodically?**
□ Yes □ No	**Is there documented non-adherence to prior HCV medications, HCV medical treatment, or failure to complete HCV disease evaluation appointments and laboratory and imaging procedures?**
□ Yes □ No	**Is the patient currently using a potent P-gp inducer drug?**
□ Yes □ No	**Are any of the following true?** *(If yes, check which applies)* □ Greater than one direct acting antiviral drug regimen used for retreatment □ Lost or stolen medication absent of good cause □ Fraudulent use of HCV medications
□ Yes □ No	**Does the patient have a history of treatment with a DAA (direct acting antiviral)?** *If yes, list previous treatment:*
□ Yes □ No	**Are the patient's comorbidities such that their life expectancy is one year or less?**
□ Yes □ No	**Does the patient have a history of failure, contraindication, or intolerance to Mavyret and sofosbuvir/velpatasvir (authorized generic of Epclusa)?** *(If yes, complete Section D above)*
DAKLINZA / OLYSIO / SOVALDI	
□ Yes □ No	**Will this be used as monotherapy?**
PEGASYS / PEGINTRON	
□ Yes □ No	**Will this be used as part of a combination antiviral treatment regimen?**
RIBAVIRIN	
□ Yes □ No	**Will this be used in combination with a direct-acting agent?**

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TECHNIVIE / VIEKIRA PAK / VIEKIRA XR	
□ Yes □ No	**Does the patient have a Child-Pugh score of B or C?**
ZEPATIER	
□ Yes □ No	**Has NS5A polymorphism testing been completed and submitted with the prior authorization request?**
RETREATMENT REQUESTS	
□ Yes □ No	**Was the patient adherent to previous DAA therapy as evidenced by medical records?**
□ Yes □ No	**Was the prior therapy discontinued due to adverse effects from the DAA?**
□ Yes □ No	**Is the medical record provided which documents these adverse effects and recommendation of discontinuation by treatment provider?** *If yes, list adverse effects:*
□ Yes □ No	**Does the patient commit to the documented planned course of treatment including anticipated laboratory, imaging tests, and prescriber provider visits?**
□ Yes □ No	**Is the life expectancy less than 12 months and cannot be remediated by treating the HCV infection, by transplantation, or by other directed therapy?**
□ Yes □ No	**Is this considered an experimental service as defined in R9-22-203?**

Physician Signature: _____ Date: _____