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: _____

Section B - Physician 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)***

□ **Ribavirin Product Requested (Include Strength):**	**Ribavirin Directions of Use:**
□ **Inferferon Product Requested (Include Strength):**	**Interferon Directions of Use:**
□ **Sovaldi**	**Sovaldi Directions of Use:**
□ **Olysio**	**Olysio Directions of Use:**
□ **Zepatier** □ **Epclusa** □ **Mavyret**	**Directions of Use:**
□ **Victrellis** □ **Incivek** □ **Other Agent**	**Directions of Use:**
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)
□ Gentoype 1 □ Gentoype 2 □ Gentoype 3 □ Gentoype 4 □ Other Gentoype (Must Specify): _____

Prescriber Specialty:
□ **Hepatologist** □ **Gastroenterologist** □ **Infectious Disease Specialist**
□ **Other (Must 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: _____
_____

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Member First name:	Member Last name:	Member DOB:

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				
4				

Clinical and Drug Specific Information

*****Please Note: All labs and/or medical records addressed below MUST be submitted*****

- Does the patient have a diagnosis of HCV which has been confirmed by detectable serum HCV RNA by quantitative assay completed within the past 90 days? □ Yes □ No
List HCV RNA and date: _____

- Has patient readiness been assessed and patient attestation of compliance is submitted and on file in the patient's medical record? (CSPMP should be used to aid in review of compliance) □ 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 HCV RNA 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? □ Yes □ No If yes, list vaccine or lab immunity test date: _____

- Has the patient had a substance use disorder in the past 12 months? □ Yes □ No

- If the patient had a substance use disorder in the past 12 months, has the patient been in remission for the past three months? □ Yes □ No

- If the patient had a substance use disorder in the past 12 months, 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 (and/or agrees to adhere to the treatment regimen)? □ 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 treatments, 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: □ Yes □ No (check which apply)
□ Greater than one course of therapy with a Direct Acting Antiviral per lifetime
□ Lost or stolen medication absent of good cause
□ Fraudulent use of HCV medications

- Are there laboratory results submitted for all of the following, collected within the past 90 days? □ Yes □ No
(Genotype, Total bilirubin, Albumin, INR, CrCl or GFR, LFTs, CBC, and Drug with alcohol screen)

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Member First name:	Member Last name:	Member DOB:

- **Are there laboratory results submitted for all of the following, collected within the past 90 days? □ Yes □ No**
  (Genotype, Viral Resistance Status (when applicable), Hepatic Status (Child-Pugh Score), Current baseline viral load, Total bilirubin, Albumin, INR, CrCl or GFR, LFTs, CBC, and Drug with alcohol screen)

- **Are there laboratory results submitted for all of the following, collected within the past 90 days? □ Yes □ No**
  (Genotype, Total bilirubin, Albumin, INR, CrCl or GFR, LFTs, CBC, and Drug with alcohol screen)

- **Has the physician submitted the following documentation? □ Yes □ No**
  □ HCV treatment history and responses
  □ Evidence of Hepatitis A & B vaccinations or laboratory evidence of immunity
  □ Current medication list

- **Does the patient have a history of treatment with a DAA? □ Yes □ No**
  If yes, list previous treatment with dates and reason for failure or discontinuation: _____

- **Are the patient's comorbidities such that their life expectancy is one year or less? □ Yes □ No**

Requests for Retreatment:

- **Was the patient adherent to previous DAA therapy as evidenced by medical records and/or pharmacy prescription claims? □ 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? □ Yes □ No**
  If yes, list adverse effects: _____

- **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? □ Yes □ No**

Physician Signature: _____ **Date:** _____

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