

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:
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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

<input type="checkbox"/> Yes <input type="checkbox"/> 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? <i>If yes, list HCV RNA and date:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has patient readiness been assessed and patient attestation of compliance is submitted and on file in the patient's medical record?
<input type="checkbox"/> Yes <input type="checkbox"/> 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?
<input type="checkbox"/> Yes <input type="checkbox"/> 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)?
<input type="checkbox"/> Yes <input type="checkbox"/> 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? <i>If yes, list vaccine or lab immunity test date:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient had a substance use disorder in the past 12 months?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient been in remission for the past three months?
<input type="checkbox"/> Yes <input type="checkbox"/> 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?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient participating in a treatment adherence program?
<input type="checkbox"/> Yes <input type="checkbox"/> No	If the patient is prescribed ribavirin, will the provider monitor hemoglobin levels periodically?
<input type="checkbox"/> Yes <input type="checkbox"/> 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?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient currently using a potent P-gp inducer drug?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are any of the following true? (If yes, check which applies) <input type="checkbox"/> Greater than one direct acting antiviral drug regimen used for retreatment <input type="checkbox"/> Lost or stolen medication absent of good cause <input type="checkbox"/> Fraudulent use of HCV medications
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of treatment with a DAA (direct acting antiviral)? <i>If yes, list previous treatment:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are the patient's comorbidities such that their life expectancy is one year or less?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of failure, contraindication, or intolerance to Mavyret <u>and</u> sofosbuvir/velpatasvir (authorized generic of Epclusa)? (If yes, complete Section D above)

DAKLINZA / OLYSIO / SOVALDI

<input type="checkbox"/> Yes <input type="checkbox"/> No	Will this be used as monotherapy?
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PEGASYS / PEGINTRON

<input type="checkbox"/> Yes <input type="checkbox"/> No	Will this be used as part of a combination antiviral treatment regimen?
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RIBAVIRIN

<input type="checkbox"/> Yes <input type="checkbox"/> No	Will this be used in combination with a direct-acting agent?
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Member Last Name:	Member First Name:	Date of Birth:
TECHNIVIE / VIEKIRA PAK / VIEKIRA XR		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a Child-Pugh score of B or C?	
ZEPATIER		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has NS5A polymorphism testing been completed and submitted with the prior authorization request?	
RETREATMENT REQUESTS		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Was the patient adherent to previous DAA therapy as evidenced by medical records?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Was the prior therapy discontinued due to adverse effects from the DAA?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the medical record provided which documents these adverse effects and recommendation of discontinuation by treatment provider? <i>If yes, list adverse effects:</i>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient commit to the documented planned course of treatment including anticipated laboratory, imaging tests, and prescriber provider visits?	
<input type="checkbox"/> Yes <input type="checkbox"/> 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?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this considered an experimental service as defined in R9-22-203?	

Physician Signature: _____ **Date:** _____

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