ROCKY MOUNTAIN HEALTH PLANS®
A UnitedHealthcare Company

Prior Authorization Request Form
Fax Back To: (866) 940-7328
Phone: (800) 310-6826

Specialty Medication Prior Authorization Cover Sheet

(This cover sheet should be submitted along with a Pharmacy Prior Authorization Medication Fax Request Form. Please refer to www.uhcprovider.com for medication fax request forms.)

Patient Information

Patient's Name:

Insurance ID: Date of Birth: Height: Weight:

Address: Apartment #:

City: State: Zip Code:

Phone Number: Alternate Phone: Sex: ☐ Male ☐ Female

Provider Information

Provider's Name: Provider ID Number:

Address: City: State: Zip Code:

Suite Number: Building Number:

Phone Number: Fax number:

Provider's Specialty:

Medication Information

Medication: Quantity: ICD10 Code:

Directions: Diagnosis: Refills:

Physician Signature**: Initial here if DAW:

Physician Signature**: By signing above, the physician is providing the specialty pharmacy with a prescription that can be used to facilitate the dispensing and/or coordination of delivery for the requested medication.

Medication Instructions

Has the patient been instructed on how to **Self-Administer**? ☐ Yes ☐ No

Is this medication a **New Start**? ☐ Yes ☐ No

If continuation please provide the following: Initiation Date: / / Date of Last Dose: / /

Is there documentation of positive clinical response to current therapy? ☐ Yes ☐ No

****Please attach any pertinent clinical information that would pertain to support stated diagnosis. Additional clinical information may be needed depending on your patients plan, including medication(s) previously tried and failed.**

Delivery Instructions

Note: Delivery coordination requires a "**Physician Signature**" above and complete "**Provider Information**" and "**Patient Information**"
Note: All necessary ancillary supplies are provided free of charge to the patient at the time of delivery

Ship to: Physician's Office ☐ Patient's Address ☐ Date medication is needed: / /

Medication Administered: Home Health ☐ Self-Administered ☐ LTC ☐ Physician's Office ☐

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Hepatitis C - Colorado
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 Information:		

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

Medication:	**Strength:**
Directions for use:	**Quantity:**
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? _____

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS

Select the patient's genotype:
□ Genotype 1 □ Genotype 2 □ Genotype 3 □ Genotype 4 □ Genotype 5 □ Genotype 6
□ Other Genotype (Must Specify): _____

Please select one of the following:
□ Compensated cirrhosis (Child-Pugh A) □ Decompensated cirrhosis (Child-Pugh B or C) □ No Cirrhosis

Please select one of the following:
□ Patient is treatment naïve □ Patient is treatment experienced

Document the patient's weight: _____ Kg

Duration of treatment: □ 8 weeks □ 12 weeks □ 16 weeks □ 24 weeks □ Other: _____ weeks

□ **Yes** □ **No**	**Will the requested medication be used in combination with any of the following?** *(If yes, check which applies)* □ Peginterferon alfa □ Ribavirin
□ **Yes** □ **No**	**Is the patient ineligible for any of the following?** *(If yes, check which applies)* □ Peginterferon alfa □ Ribavirin
□ **Yes** □ **No**	**Has the patient received, or is in the process of receiving, full courses of both Hepatitis A and Hepatitis B vaccinations, or does the patient have immunity?**
□ **Yes** □ **No**	**Has the patient had genotyping results within 1 year before anticipated therapy start date?**
□ **Yes** □ **No**	**Is the requested medication prescribed by an infectious disease specialist, gastroenterologist, or hepatologist?**
□ **Yes** □ **No**	**Is the requested medication prescribed by any primary care provider in consultation with an infectious disease specialist, gastroenterologist, or hepatologist?**
□ **Yes** □ **No**	**For treatment naïve patients without cirrhosis, is the requested medication prescribed by any primary care provider who has completed the HCV ECHO (Extension for Community Healthcare Outcome) series (four, 1-hour trainings)?**
□ **Yes** □ **No**	**Does the physician attest to the patient's readiness for adherence [which may include assessment tools such as PREP-C (Psychosocial Readiness Evaluation and Preparation for Hepatitis C Treatment)]?**
□ **Yes** □ **No**	**Does the physician attests to the patient having Chronic HCV infection (presence of HCV RNA viral load for greater than or equal to 6 months to confirm infection is not acute or evidence that the infection has not spontaneously resolved)?**
□ **Yes** □ **No**	**For women of childbearing potential, has a serum pregnancy testing been conducted within 30 days of expected direct-acting antiviral start date?**
□ **Yes** □ **No**	**Will the provider be submitting ALL of the following laboratory tests within 6 months of initiating therapy?** *DOCUMENTATION REQUIRED* • **CBC (complete blood count)** • **Hepatic Function Panel [i.e. albumin, total and direct bilirubin, ALT (alanine aminotransferase), AST (aspartate aminotransferase), and alkaline phosphatase levels]** • **Calculated GFR (glomerular filtration rate)** • **If cirrhosis is present, calculation of the CTP (Child-Turcotte-Pugh) score** • **Transplant status as applicable (pre-, post-, N/A)**
□ **Yes** □ **No**	**For treatments ≥ 12 weeks in duration, does the physician attest that if the week 4 HCV RNA is detectable (> 25 copies) while on therapy, HCV RNA will be reassessed in 2 weeks; and if the repeated HCV RNA level has not decreased [i.e. > 1 log10 IU (international units)/mL from nadir], all treatment will be discontinued?**
□ **Yes** □ **No**	**Does the patient have a life expectancy ≥ 12 month?**
□ **Yes** □ **No**	**Is the patient's renal function greater than 30mL/min (including those requiring hemodialysis or peritoneal dialysis?**

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USE WITH RIBAVARIN-CONTAINING REGIMENS	
□ Yes □ No	**Is the patient a pregnant female or a male with a pregnant female partner?**
□ Yes □ No	**Do women of childbearing potential and their male partners attest that they will use two forms of effective (non-hormonal) contraception during treatment?**
□ Yes □ No	**Does the patient meet any of the following?** *If yes, check which applies* □ Known hypersensitivity to ribavirin □ Autoimmune hepatitis □ Hemoglobinopathies □ Creatinine clearance < 50 mL/min (milliliters/minute) □ Co-administered with didanosine
HARVONI (LEDIPASVIR/SOFOSBUVIR)	
Document the patient's pre-treatment HCV RNA level: _____ million IU/mL	
□ Yes □ No	**Is the patient a liver transplant recipient?**
□ Yes □ No	**Has the patient had a prior failure with Sovaldi (sofosbuvir)?**
MAVYRET	
□ Yes □ No	**Is the patient treatment-experienced (previously treated) with any of the following?** *(If yes, check all that apply applies)* □ Daklinza □ Peg-interferon □ Harvoni □ Ribavirin □ Incivek □ Sofosbuvir (Sovaldi) □ Olysio □ Victrelis
SOVALDI	
□ Yes □ No	**Will documentation indicating an acceptable rationale for not prescribing a preferred treatment regimen (acceptable rationale may include: patient-specific medical contraindications to a preferred treatment, patient has initiated treatment on a non-preferred drug and needs to complete therapy) be submitted along with this fax?** *DOCUMENTATION REQUIRED*
□ Yes □ No	**Is the patient awaiting a liver transplant or has liver carcinoma?**
VOSEVI	
□ Yes □ No	**Will documentation indicating an acceptable rationale for not prescribing a preferred treatment regimen (acceptable rationale may include: patient-specific medical contraindications to a preferred treatment, patient has initiated treatment on a non-preferred drug and needs to complete therapy) be submitted along with this fax?** *DOCUMENTATION REQUIRED*
□ Yes □ No	**Is the patient treatment experienced with a regimen containing sofosbuvir with or without an NS5A inhibitor (e.g., Daklinza, Viekira Pak, Harvoni, or Epclusa)?**
ZEPATIER	
□ Yes □ No	**Will documentation indicating an acceptable rationale for not prescribing a preferred treatment regimen (acceptable rationale may include: patient-specific medical contraindications to a preferred treatment, patient has initiated treatment on a non-preferred drug and needs to complete therapy) be submitted along with this fax?** *DOCUMENTATION REQUIRED*
□ Yes □ No	**Does the patient have baseline NS5A polymorphisms on amino acids 28/30/31/93?**
□ Yes □ No	**Has the patient failed treatment with peg-interferon alfa and ribavirin?**

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RE-TREATMENT REQUESTS

Document previous regimen medications and dates treated:

Select the patient's genotype of previous HCV infection:
□ Genotype 1 □ Genotype 2 □ Genotype 3 □ Genotype 4 □ Genotype 5 □ Genotype 6
□ Other Genotype (Must Specify): _____

Document any information regarding adherence to previously trialed regimen(s) and current chronic medications:

Document adverse effects experienced from previous treatment regimen:

Document concomitant therapies during previous treatment regimen:

Provider Signature: _____ **Date:** _____