

Hepatitis C Medications - Pennsylvania 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.

Office contact name/phone:		Prescriber name:	
LTC facility contact/phone:		State license #:	NPI:
total # pages:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:
Requested drug #1:	Directions:	Qty:	<input type="checkbox"/> 8 weeks <input type="checkbox"/> 16 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> Other: _____
Requested drug #2:	Directions:	Qty:	<input type="checkbox"/> 8 weeks <input type="checkbox"/> 16 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> Other: _____
Is the beneficiary currently being treated with the requested drug?			<input type="checkbox"/> No <input type="checkbox"/> Yes – Therapy start date: _____

SUBMIT DOCUMENTATION from the medical record for all items below.

1. Baseline quantitative HCV RNA and date of testing.
2. Metavir fibrosis score documented by a recent noninvasive test and date of testing.
3. Genotype if one of the following (check the appropriate box for the beneficiary):
 - ☐ The beneficiary is prescribed a non-pangenotypic regimen.
 - ☐ The beneficiary is hepatitis C treatment experienced.
 - ☐ The beneficiary has decompensated cirrhosis.
 - ☐ The beneficiary is treatment-naïve (with cirrhosis) and prescribed sofosbuvir/velpatasvir.
4. RAS (resistance-associated substitutions) testing and date of testing if one of the following (check the appropriate box for the beneficiary):
 - ☐ The beneficiary is genotype 1a and prescribed elbasvir/grazoprevir.
 - ☐ The beneficiary is genotype 1a, treatment-experienced, and prescribed ledipasvir/sofosbuvir.
 - ☐ The beneficiary is genotype 3, treatment-naïve (with cirrhosis) or treatment-experienced (without cirrhosis), and prescribed 12 weeks of sofosbuvir/velpatasvir.
5. Results of HIV (HIV Ag/Ab) screening.
6. For requests for NON-PREFERRED agents, documentation that the beneficiary tried and failed or has a contraindication or intolerance to the preferred Hepatitis C Agents.

ATTESTATION from the prescriber for one of the items below.

Check the appropriate box for the beneficiary.

- ☐ The beneficiary is hepatitis C treatment naïve.
- ☐ The beneficiary has been treated for hepatitis C with the following treatment regimen:

Prescriber Signature:

Date: