UnitedHealthcare Community Plan

Hepatitis C Medications – Rhode Island
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:	**Quantity:**
Medication 2:	**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? _____

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 trained Clinician who is a Preferred Provider approved by EOHHS

- 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				
4				

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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 □ Agreement to submit post-treatment viral load data if requested	
□ Yes □ No	**Is this a continuation of treatment when transitioning between publicly funded delivery systems (e.g. between fee for service Medicaid and managed care Medicaid, between managed care Medicaid and fee for service Medicaid, or between the department of corrections and the Medicaid program)?**
□ Yes □ No	**Does the patient indicate a willingness to comply with treatment and monitoring plans as documented by having a signed "Patient Contract"?**
□ Yes □ No	**Does the patient have documented chronic hepatitis C, stage 0 through 4, including the test used to determine disease stage?** *List Stage:*
□ Yes □ No	**If the patient is F3-F3, is the patient managed by a provider on the Rhode Island Medicaid Hepatitis C Preferred Provider List who either assumes direct responsibility for care or who, after consultation and establishing a treatment plan, co-manages the patient with the primary care provider?**
□ Yes □ No	**If the patient has Decompensated liver disease (CTP B or greater), is the patient referred to a physician with experience in managing such disease—ideally at a center with liver transplant capabilities?**
□ Yes □ No **□ The patient is treatment naïve**	**Is there history of prior hepatitis C treatment, if relevant, included in the request?** *(If yes, complete Section D above)*
□ Yes □ No	**Please select one of the following: □ Compensated □ Decompensated □ Patient does not have**
	Duration of treatment: □ 8 weeks □ 12 weeks □ 16 weeks □ 24 weeks **□ Other: _____ weeks**
□ Yes □ No	**Is a summary of current clinical status including hepatic function data and, as appropriate, determination of compensated/decompensated cirrhosis included?**
□ Yes □ No	**Is the hepatitis C genotype, quantitative viral load, and date of testing included, and testing is within 90 days of request?**
MAVYRET	
□ Yes □ No	**Does the patient have one of the following? (check which applies)** □ Genotype 1, 2, 3, 4, 5, or 6 and treatment naïve □ Genotype 1 and treatment-experienced (previously treated) with an NS5A inhibitor without prior treatment with an NS3/4A protease inhibitor □ Genotype 1 and treatment-experienced (previously treated) with an NS3/4A protease inhibitor without prior treatment with an NS5A inhibitor □ Genotype 1, 2, 3, 4, 5, or 6 and treatment-experienced (previously treated) with interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A protease inhibitor or NS5A inhibitor □ None of the above
VOSEVI	
□ Yes □ No	**Has the patient been previously treated with an NS3/4A inhibitor?**
□ Yes □ No	**Does the patient have a history of intolerance or contraindication to Mavyret, or is currently on Vosevi therapy?** *(If yes, complete Section D above)*
□ Yes □ No	**Does the any of the following apply to the patient?** □ Genotype 1 and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing an NS5A inhibitor □ Genotype 2, 3, 4, 5, or 6, and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing an NS5A inhibitor □ Genotype 1a, and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing sofosbuvir without an NS5A inhibitor. □ Genotype 3, and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing sofosbuvir without an NS5A inhibitor □ None of the above

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NON-POLICY REGIMENS	
□ Yes □ No	**Is the patient completing a cycle therapy which was initiated prior to current policy implementation?**
□ Yes □ No	**Is there detailed clinical documentation of the need for an alternative, non-preferred treatment?** *If yes, list need:*

Physician Signature: _____ Date: _____