PRIOR AUTHORIZATION REQUEST

Hepatitis C

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1 What medication is being requested?

[] Mayvret (If checked, go to 2)

[] Sofosbuvir-Velpatasvir (If checked, go to 35)

[] Vosevi (If checked, go to 50)

[] Ledipasvir-sofosbuvir (If checked, no further questions)

[] Zepatier (If checked, no further questions)

If you have any questions, call: 1-888-258-8250

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	[] Other (If checked, no further questions)		
2	Is the patient 3 years of age or older? [If no, no further questions.]	Yes	No
3	Does the patient have a diagnosis of chronic hepatitis C infection? [Note: persistent and detectable serum hepatitis C virus (HCV) ribonucleic acid (RNA) for a period greater than or equal to 6 months.] [If no, no further questions.]	Yes	No
4	Has documentation of serum hepatitis C virus (HCV) ribonucleic acid (RNA), liver function labs (ALT/AST/albumin/ total bilirubin/INR) obtained within the last 90-days been submitted? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
5	Has documentation been provided to show the patient has undergone a liver biopsy or non-invasive test to evaluate liver fibrosis status? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
6	Does the patient have an active hepatitis B virus (HBV) infection? ACTION REQUIRED: Submit supporting documentation. [If no, skip to question 8.]	Yes	No
7	Does the provider attest to monitor for HBV reactivation? [If no, no further questions.]	Yes	No
8	Does the provider attest that the patient hasn't been diagnosed with a comorbid condition that could result in a limited life expectancy? [Note: Life expectancy is less than 12 months at time of treatment request.] [If no, no further questions.]	Yes	No
9	Does any of the following apply to the patient? [] Post kidney or liver transplant infection/reactivation (if checked, go to 30) [] No history of kidney or liver transplant (if checked, go to 10)		
10	Is the patient treatment naive? [Note: Patient has not been treated with peginterferon alfa/ribavirin, an HCV NS3/4A protease inhibitor or NS5A inhibitor.] [If yes, skip to question 12.]	Yes	No
11	Is the patient treatment experienced? [Note: Patient has been treated with peginterferon alfa/ribavirin, an HCV NS3/4A protease inhibitor or NS5A inhibitor.] [If yes, skip to question 15.]	Yes	No

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12	What is the patient's genotype? ACTION REQUIRED: Submit supporting documentation. [] Genotype 1 (If checked, go to 13) [] Genotype 2 (If checked, go to 13) [] Genotype 3 (If checked, go to 13) [] Genotype 4 (If checked, go to 13) [] Genotype 5 (If checked, go to 13) [] Genotype 6 (If checked, go to 13) [] Other (If checked, no further questions)		
13	What is the patient's current liver status? [] No Cirrhosis (If checked, go to 14) [] Compensated cirrhosis [Child-Pugh A] (If checked, go to 14) [] Other (if checked, no further questions)		
14	Will the requested duration of treatment exceed 8 weeks? [No further questions.]	Yes	No
15	Has the patient been previously treated with a regimen containing (peg)interferon, ribavirin and/or sofosbuvir without prior treatment with an NS3/4A protease inhibitor or NS5A inhibitor? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 18.]	Yes	No
16	Has the patient been previously treated with a regimen containing an NS5A inhibitor without prior treatment with an NS3/4A protease inhibitor? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 24.]	Yes	No
17	Has the patient been previously treated with a regimen containing an NS3/4A protease inhibitor without prior treatment with an NS5A inhibitor? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 27.] [If no, no further questions.]	Yes	No
18	What is the patient's genotype? ACTION REQUIRED: Submit supporting documentation.		

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[] Genotype 1 (If checked, go to 19)

[] Genotype 2 (If checked, go to 19)

[] Genotype 3 (If checked, go to 22)

[] Genotype 4 (If checked, go to 19)

[] Genotype 5 (If checked, go to 19)

[] Genotype 6 (If checked, go to 19)

[] Other (If checked, no further questions)

19 What is the patient's current liver status?

[] No Cirrhosis (If checked, go to 20)

[] Compensated cirrhosis [Child-Pugh A] (If checked, go to 21)

[] Other (If checked, no further questions)

20 Will the requested duration of treatment exceed 8 weeks? Yes No
[No further questions.]

21 Will the requested duration of treatment exceed 12 weeks? Yes No
[No further questions.]

22 What is the patient's current liver status?

[] No Cirrhosis (If checked, go to 23)

[] Compensated cirrhosis [Child-Pugh A] (If checked, go to 23)

[] Other (If checked, no further questions)

23 Will the requested duration of treatment exceed 16 weeks? Yes No
[No further questions.]

24 What is the patient's genotype? ACTION REQUIRED: Submit supporting documentation.

[] Genotype 1 (If checked, go to 25)

[] Genotype 2 (If checked, no further questions)

[] Genotype 3 (If checked, no further questions)

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[] Genotype 4 (If checked, no further questions)

[] Genotype 5 (If checked, no further questions)

[] Genotype 6 (If checked, no further questions)

[] Other (If checked, no further questions)

25 What is the patient's current liver status?

[] No Cirrhosis (If checked, go to 26)

[] Compensated cirrhosis [Child-Pugh A] (If checked, go to 26)

[] Other (If checked, no further questions)

26 Will the requested duration of treatment exceed 16 weeks? Yes No
[No further questions.]

27 What is the patient's genotype? ACTION REQUIRED: Submit supporting documentation.

[] Genotype 1 (If checked, go to 28)

[] Genotype 2 (If checked, no further questions)

[] Genotype 3 (If checked, no further questions)

[] Genotype 4 (If checked, no further questions)

[] Genotype 5 (If checked, no further questions)

[] Genotype 6 (If checked, no further questions)

[] Other (If checked, no further questions)

28 What is the patient's current liver status?

[] No Cirrhosis (If checked, go to 29)

[] Compensated cirrhosis [Child-Pugh A] (If checked, go to 29)

[] Other (If checked, no further questions)

29 Will the requested duration of treatment exceed 12 weeks? Yes No
[No further questions.]

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30	What is the patient's genotype? ACTION REQUIRED: Submit supporting documentation. [] Genotype 1 (If checked, go to 31) [] Genotype 2 (If checked, go to 33) [] Genotype 3 (If checked, go to 32) [] Genotype 4 (If checked, go to 33) [] Genotype 5 (If checked, go to 33) [] Genotype 6 (If checked, go to 33) [] Other (If checked, no further questions)		
31	Has the patient been previously treated with a regimen containing an NS5A inhibitor without prior treatment with an NS3/4A protease inhibitor? ACTION REQUIRED: Submit supporting documentation. [If no, skip to question 33.] [If yes, skip to question 34.]	Yes	No
32	Has the patient been previously treated with a regimen containing (peg)interferon, ribavirin and/or sofosbuvir without prior treatment with an NS3/4A protease inhibitor or NS5A inhibitor? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 37.]	Yes	No
33	Will the requested duration of treatment exceed 12 weeks? [No further questions.]	Yes	No
34	Will the requested duration of treatment exceed 16 weeks? [No further questions.]	Yes	No
35	Is the patient 3 years of age or older? [If no, no further questions.]	Yes	No
36	Does the patient have a diagnosis of chronic hepatitis C infection? [Note: persistent and detectable serum hepatitis C virus (HCV) RNA for a period greater than or equal to 6 months.] [If no, no further questions.]	Yes	No
37	Has documentation of serum HCV RNA, liver function labs (ALT/AST/albumin/total bilirubin/INR) obtained within the last 90-days been submitted? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No

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38	Has documentation been provided to show the patient has undergone a liver biopsy or non-invasive test to evaluate liver fibrosis status? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
39	Does the patient have an active hepatitis B virus (HBV) infection? ACTION REQUIRED: Submit supporting documentation. [If no, skip to question 41.]	Yes	No
40	Does the provider attest to monitor for HBV reactivation? [If no, no further questions.]	Yes	No
41	Does the provider attest that the patient hasn't been diagnosed with a comorbid condition that could result in a limited life expectancy? [Note: Life expectancy is less than 12 months at time of treatment request.] [If no, no further questions.]	Yes	No
42	Does any of the following apply to the patient? [] Post kidney or liver transplant infection/reactivation (If checked, go to 47) [] No history of kidney or liver transplant (If checked, go to 43)		
43	Is the patient treatment naive? [Note: Patient has not been treated with peginterferon alfa/ribavirin, an HCV NS3/4A protease inhibitor or NS5A inhibitor.] [If yes, skip to question 45.]	Yes	No
44	Is the patient treatment experienced? [Note: Patient has been treated with peginterferon alfa/ribavirin or an HCV NS3/4A protease inhibitor.] [If no, no further questions.]	Yes	No
45	What is the patient's genotype? ACTION REQUIRED: Submit supporting documentation. [] Genotype 1 (If checked, go to 46) [] Genotype 2 (If checked, go to 46) [] Genotype 3 (If checked, go to 46) [] Genotype 4 (If checked, go to 46) [] Genotype 5 (If checked, go to 46) [] Genotype 6 (If checked, go to 46)		

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	[] Other (If checked, no further questions)		
46	What is the patient's current liver status? [] No Cirrhosis (If checked, go to 47) [] Compensated cirrhosis [Child-Pugh A] (If checked, go to 47) [] Decompensated cirrhosis [Child-Pugh B or C] (If checked, go to 48) [] Other (if checked, no further questions)		
47	Will the requested duration of treatment exceed 12 weeks? [No further questions.]	Yes	No
48	Will the requested duration of treatment exceed 12 weeks? [If yes, no further questions.]	Yes	No
49	Will the patient be prescribed concomitant ribavirin therapy for 12 weeks? [No further questions.]	Yes	No
50	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
51	Does the patient have a diagnosis of chronic hepatitis C infection? [Note: Persistent and detectable serum hepatitis C virus (HCV) RNA for a period greater than or equal to 6 months.] [If no, no further questions.]	Yes	No
52	Has documentation of serum HCV RNA, liver function labs (ALT/AST/albumin/total bilirubin/INR) obtained within the last 90-days been submitted? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
53	Has documentation been provided to show the patient has undergone a liver biopsy or non-invasive test to evaluate liver fibrosis status? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
54	Does the patient have an active hepatitis B virus (HBV) infection? ACTION REQUIRED: Submit supporting documentation. [If no, skip to question 56.]	Yes	No
55	Does the provider attest to monitor for HBV reactivation? [If no, no further questions.]	Yes	No
56	Does the provider attest that the patient hasn't been diagnosed with a comorbid condition that could result in a limited life expectancy?	Yes	No

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[Note: Life expectancy is less than 12 months at time of treatment request.]
[If no, no further questions.]

57 What is the patient's current liver status?

[] No Cirrhosis (If checked, go to 58)

[] Compensated cirrhosis [Child-Pugh A] (If checked, go to 58)

[] Other (If checked, no further questions)

58 Has the patient been previously treated with a regimen containing an NS5A inhibitor? Yes No
ACTION REQUIRED: Submit supporting documentation.
[If yes, skip to question 60.]

59 Has the patient been previously treated with a regimen containing sofosbuvir without prior treatment with an NS5A inhibitor? ACTION REQUIRED: Submit supporting documentation. Yes No
[If yes, skip to question 62.]
[If no, no further question.]

60 What is the patient's genotype? ACTION REQUIRED: Submit supporting documentation.

[] Genotype 1 (If checked, go to 61)

[] Genotype 2 (If checked, go to 61)

[] Genotype 3 (If checked, go to 61)

[] Genotype 4 (If checked, go to 61)

[] Genotype 5 (If checked, go to 61)

[] Genotype 6 (If checked, go to 61)

[] Other (If checked, no further questions)

61 Will the requested duration of treatment exceed 12 weeks? Yes No
[No further questions.]

62 What is the patient's genotype? ACTION REQUIRED: Submit supporting documentation.

[] Genotype 1a (If checked, go to 63)

[] Genotype 1b (If checked, no further questions)

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[] Genotype 2 (If checked, no further questions)

[] Genotype 3 (If checked, go to 63)

[] Genotype 4 (If checked, no further questions)

[] Genotype 5 (If checked, no further questions)

[] Genotype 6 (If checked, no further questions)

[] Other (If checked, no further questions)

63 Will the requested duration of treatment exceed 12 weeks? Yes No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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