



PRIOR AUTHORIZATION REQUEST FORM FOR HEPATITIS C TREATMENT

Instructions: Please complete ALL FIELDS and FAX COMPLETED FORM TO 1-855-620-1868.

Member Name		Prescriber FULL Name/Specialty		
Member ID #	Date of Birth	Prescriber NPI		
Member's Telephone Number		Office Address		
Diagnosis of chronic hepatitis C <input type="checkbox"/> Yes <input type="checkbox"/> No				
Genotype		Office Phone #		
Does the patient have decompensated liver disease? <input type="checkbox"/> Yes <input type="checkbox"/> No		Office Fax #		
REQUESTED MEDICATION(S)				
Drug Name	Drug Strength	Drug Dosage Form	Drug Dosing	Length of Treatment
New start or a continuation of therapy? <input type="checkbox"/> New start <input type="checkbox"/> Continuation Start Date _____				
Previous therapies used to treat hepatitis C				
Drug & Dose Used	Start Date	Stop Date	Therapeutic Outcome	
REQUIRED DOCUMENTATION – Please submit all required clinical notes/lab reports in reference to this request.				
<ul style="list-style-type: none"> • If awaiting liver transplant, is the patient suitable for transplant per Milan criteria? <input type="checkbox"/> Yes <input type="checkbox"/> No • Substance or alcohol use: Patients with active substance or alcohol use disorders should be considered for therapy on a case-by-case basis, and care should be coordinated with substance use treatment specialists. 				
Child Pugh Score: _____ Total Serum Bilirubin: _____ Albumin: _____ INR: _____ CrCl: _____ Post liver transplant: <input type="checkbox"/> Yes <input type="checkbox"/> No Ascites: <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatic encephalopathy: <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis B positive: <input type="checkbox"/> Yes <input type="checkbox"/> No Human Immunodeficiency Virus (HIV) positive: <input type="checkbox"/> Yes <input type="checkbox"/> No				

If yes, is member on stable ARV treatments? Yes No

The following document submissions are required for review:

- 1) HCV-RNA viral load labs within the past 90 days
- 2) Urine toxicology within the past 30 days
- 3) Fibrosis score results (Metavir, Ishak, Apri, FibroSure, FibroScan)
- 4) Listed name of the specialty pharmacy to fill the medication
- 5) Most recent complete blood count (CBC)
- 6) CD4 labs within the previous 90 days if co-infected with HIV-1

Check off the following items that have been completed:

- Patient has been given an explanation of the importance of adherence, and has agreed to adhere to and complete the drug regimen as prescribed.
- Risks of hepatotoxic drugs including acetaminophen have been explained to the patient.

REQUEST FOR EXPEDITED REVIEW

By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

By signing below, you attest that all statements on this form are true to the best of your knowledge.

Prescriber's Signature _____ Date _____