Physician Request Form for Hepatitis C Therapies
Fax to Pharmacy Services at **215-937-5018**, or call **800-588-6767**
to speak to a representative. ***Form must be completed for processing***.

Keystone First
Sunray
Specialty Pharmacy

Patient name:_____ Patient ID: _____
Patient address: _____ Date of Birth: _____
City: _____ State: _____ Zip: _____ Weight: _____
Prescriber name: _____ NPI: _____
Prescriber address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Fax: _____
Contact name: _____
Requested Regimen, Dose and Duration: _____

Provider attests to all of the following:

- Member has a limited life expectancy due to non-liver related comorbid condition (less than 12 months): ☐Yes ☐No
- That they have documented completion of the following: ☐Yes ☐No
  - Hepatitis B immunization series **OR** Hepatitis B screening (sAb/sAg and cAb/cAg)

  AND
  - Quantitative HBV DNA if positive for hepatitis BsAg or cAb or cAg

  AND
  - If there is detectable HBV DNA, will be treated for Hepatitis B

  OR
  - If negative for Hepatitis BsAb, is being vaccinated against Hepatitis B

  Patient is infected with HBV? ☐Yes ☐No
- That they have documented HIV screening (HIV Ag/Ab): ☐Yes ☐No, and if confirmed positive by HIV-1/HIV-2 differentiation immunoassay:
  - Is being treated for HIV

  OR
  - Is not being treated for HIV and the medical record documents the rationale for not being treated

  Patient is infected with HIV? ☐Yes ☐No
- All potential drug interactions with concomitant medications have been addressed: ☐Yes ☐No
- Does the member currently have issues with compliance?: ☐Yes ☐No
- Is the member actively abusing alcohol or IV drugs or does the member have a history of alcohol or IV drug abuse? ☐Yes* ☐No

  *If yes, has the member been counseled regarding the risks of alcohol or IV drug abuse, and an offer of referral for substance abuse disorder treatment has been made?: ☐Yes ☐No
- Provider attests that the member is committed to the treatment plan, including lab monitoring and SVR12 lab testing will be completed and submitted to health plan: ☐Yes ☐No
- Member's previous treatment history and response: _____
- Member completed treatment: ☐Yes ☐No
- Fibrosis Level: _____
- Is the member cirrhotic? ☐Yes* ☐No

  *If yes, provide Child Turcotte Pugh Class: ☐ Class A ☐Class B ☐ Class C

Lab testing required (attach copy of results/MUST be submitted with request):

- **Genotype** (with subtype if provided): _____
- **RASs testing as indicated in guidelines** (resistance-associated substitutions, previously called RAVs)
- **Detectable HCV RNA viral load**
- **CBC** (**within 3 months** ONLY if regimen contains ribavirin)
- **Pregnancy test** (**within 1 month** and ONLY if regimen contains ribavirin and the member is of child bearing age)

Deliver to:

☐ Member's Home ☐Physician's Office ☒Member's Preferred Pharmacy Name/Phone#): Sunray Specialty Pharmacy/888-260-9555

☒ I acknowledge that the member agrees with the pharmacy chosen for delivery of this medication

Prescriber Signature: _____ **Print Name:** _____ **Date**: _____

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