Sunray Specialty Pharmacy

Keystone First
Community HealthChoices
Coverage by Vista Health Plan, an independent licensee of the Blue Cross and Blue Shield Association.

Physician Request Form for Hepatitis C Therapies

Fax to Pharmacy Services at **855-851-4058**, or call **1-855-851-4088** to speak to a representative. ***Form must be completed for processing***.

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: _____

Prescriber specialty: ☐Hepatology ☐ Gastroenterology ☐Infectious Disease ☐Transplant ☐HIV

Requested Regimen, Dose and Duration: _____

Provider attests to all of the following:

- Participant has a limited life expectancy due to non-liver related comorbid condition (less than 12 months): ☐Yes ☐No
- Participant has been screened for hepatitis B (HBV) and human immunodeficiency virus (HIV): ☐Yes ☐No
  Patient is infected with HBV? ☐Yes ☐No Patient is infected with HIV? ☐ Yes ☐ No
- All potential drug interactions with concomitant medications have been addressed: ☐Yes ☐No
- Does the Participant currently have issues with compliance?: ☐Yes ☐No
- Is the Participant actively abusing alcohol or IV drugs or does the Participant have a history of alcohol or IV drug abuse? ☐Yes* ☐No
  *If yes, has the Participant 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 Participant is committed to the treatment plan, including lab monitoring and SVR12 lab testing will be completed and submitted to health plan: ☐Yes ☐No
- Participant's previous treatment history and response: _____
- Participant completed treatment: ☐Yes ☐No
- Is the Participant cirrhotic? ☐Yes* ☐No *If Yes, provide Child Turcotte Pugh Class: ☐ Class A ☐Class B ☐ Class C
- Does Participant have hepatocellular carcinoma? ☐Yes* ☐No
  *If yes, confirmation of diagnosis was made by ultrasound, tomography, MRI, laparoscopy or biopsy: ☐Yes ☐No

Participant has ONE of the following: (<u>All applicable documentation must be included with this request</u>)

- History of liver transplant: ☐Yes* ☐No *If Yes, date of transplant: _____
- Is HIV or HBV coinfected: ☐Yes ☐No
- Serious extrahepatic manifestations of Hepatitis C: ☐Yes ☐No
- A Metavir fibrosis score of F1-F4 documented by liver biopsy, Fibroscan or blood test **(copy of result REQUIRED)**:
  ☐Yes ☐No Fibrosis Level: _____
- Physical findings consistent with substantial or advanced fibrosis: ☐Yes ☐No

Lab testing required (<u>attach copy of results</u>):

- **Genotype** (with subtype if provided)_____
- **RASs testing as indicated in guidelines** (resistance-associated substitutions, previously called RAVs)

Copies of the following lab testing results (<u>completed within 3 months of starting therapy</u>) MUST be submitted with request:

- **Detectable HCV RNA viral load**
- **TSH** (ONLY if regimen contains interferon)
- **CBC** (ONLY if regimen contains ribavirin)
- **Pregnancy test** (**within 1 month** and ONLY if regimen contains ribavirin and the Participant is of child bearing age)

Deliver to:

☐ Participant's Home ☐Physician's Office ☒Participant's Preferred Pharmacy Name/Phone#): Sunray Specialty Pharmacy 215-471-4000 x0

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

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