Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Hepatitis C Agents

Phone: 215-991-4300 Fax back to: 866-240-3712

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Patient Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):* Sunray Specialty Pharmacy	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Does the patient have a diagnosis of chronic Hepatitis C with documented genotyping?

☐ Yes ☐ No

Q2. Is documentation of the diagnosis and genotype attached to this request?

☐ Yes ☐ No

Q3. Is the prescribed dose and length of therapy consistent with FDA-approved labeling or peer-reviewed medical literature?

☐ Yes ☐ No

Q4. Is the requested drug age-appropriate for the patient according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed literature?

☐ Yes ☐ No

Q5. Is the patient actively abusing alcohol or IV drugs, or has a history of abuse?

☐ Yes ☐ No

Q6. Has prescriber counseling regarding the risks of alcohol or IV drug abuse and an offer of a referral for substance use disorder treatment been completed?

☐ Yes ☐ No

Q7. Has documentation of prescriber counseling regarding the risks of alcohol or IV drug abuse and an offer of a referral for substance use disorder treatment attached to this request?

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☐ Yes ☐ No

Q8. Is the patient's Metavir fibrosis score confirmed by recent noninvasive test such as a blood test or imaging, a Fibroscan, or findings on physical examination?

☐ Yes ☐ No

Q9. Has documentation of the recent noninvasive test such as a blood test or imaging, a Fibroscan, or findings on physical examination attached to this request?

☐ Yes ☐ No

Q10. Has the patient had a complete hepatitis B immunization series? Note: The prescriber must submit documentation.

☐ Yes ☐ No

Q11. Is documentation for the complete hepatitis B immunization series attached to this request? [If yes, skip to question 22.]

☐ Yes ☐ No

Q12. Has the patient had Hepatitis B screening (sAb, sAg, and cAb)?

☐ Yes ☐ No

Q13. Is the patient positive for hepatitis B sAg?
[If no, skip to question 19.]

☐ Yes ☐ No

Q14. Has the patient had quantitative HBV DNA results? Note: The prescriber must submit documentation.

☐ Yes ☐ No

Q15. Is documentation for the quantitative HBV DNA results attached to this request?

☐ Yes ☐ No

Q16. Is there detectable HBV DNA? Note: The prescriber must submit documentation.

☐ Yes ☐ No

Q17. Has a treatment plan for hepatitis B consistent with AASLD recommendations been developed for the patient? Note: The prescriber must submit documentation.

☐ Yes ☐ No

Q18. Has documentation for the treatment plan attached to this request?

☐ Yes ☐ No

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Q19. Is the patient negative for hepatitis B sAb?

☐ Yes ☐ No

Q20. Has a hepatitis B immunization plan or counseling to receive the hepatitis B immunization series been completed? Note: The prescriber must submit documentation.

☐ Yes ☐ No

Q21. Has documentation for the treatment plan and patient counseling attached to this request?

☐ Yes ☐ No

Q22. Has the patient had an HIV screening (HIV Ag/Ab)? Note: The prescriber must submit documentation.

☐ Yes ☐ No

Q23. Has documentation for the HIV screening attached to this request?

☐ Yes ☐ No

Q24. Is the patient HIV-positive confirmed positive by HIV-1/HIV-2 differentiation immunoassay?

☐ Yes ☐ No

Q25. Is the patient being treated for HIV?

☐ Yes ☐ No

Q26. Is there documented rationale for the beneficiary for the patient not being treated? Note: The prescriber must submit documentation.

☐ Yes ☐ No

Q27. Is documented rationale attached to this request?

☐ Yes ☐ No

Q28. Does the patient meet both of the following? A) Has documentation of AASLD-recommended resistance-associated substitution (RAS) testing and B) The patient is being prescribed a drug regimen in accordance with AASLD guidance?

☐ Yes ☐ No

Q29. Is documentation supporting the RAS testing been attached to this request?

☐ Yes ☐ No

Q30. Is the patient genotype 1a or had a previous treatment failure with a direct-acting antiretroviral (DAA) regimen?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q31. Is the patient prescribed an AASLD recommended drug regimen based on the documented results of a NS5A RAS screening?

☐ Yes ☐ No

Q32. Does the patient have a life expectancy of less than 12 months due to non-liver-related comorbid conditions?

☐ Yes ☐ No

Q33. Has a documented quantitative HCV RNA at baseline that was tested within the past 3 months? Note: The prescriber must submit documentation.

☐ Yes ☐ No

Q34. Is documentation supporting the HCV RNA testing attached to this request?

☐ Yes ☐ No

Q35. Does the patient have a history of non-adherence?

☐ Yes ☐ No

Q36. Has the causes of non-adherence to a previously prescribed hepatitis C treatment regimen been corrected or addressed?

☐ Yes ☐ No

Q37. Have all potential drug interactions been addressed by the prescriber (such as discontinuation of the interacting drug, dose reduction of the interacting drug, or counseling of the beneficiary of the risks associated with the use of both medications when they interact)?

☐ Yes ☐ No

Q38. Is the patient prescribed ribavirin?

☐ Yes ☐ No

Q39. Does the patient have a pretreatment hemoglobin of at least 10 g/dL?

☐ Yes ☐ No

Q40. Is the patient female?

☐ Yes ☐ No

Q41. Does the patient meet ALL of the following? A) The patient had a negative pregnancy test immediately prior to initiating therapy, B) The patient will use two or more forms of contraception, and C) The patient will have monthly pregnancy tests during therapy.

☐ Yes ☐ No

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Q42. Is the request for a non-preferred agent?

☐ Yes ☐ No

Q43. Does the patient have a history of therapeutic failure, contraindication, or intolerance to the preferred Hepatitis C Agents appropriate for the beneficiary's genotype according to peer-reviewed medical literature?

☐ Yes ☐ No

Q44. Is the patient currently receiving treatment with the same non-preferred Hepatitis C Agent?

☐ Yes ☐ No

Q45. Does the patient have a documented commitment to adherence with the planned course of treatment and mutual prescriber and Departmental monitoring?

☐ Yes ☐ No

Q46. Has documentation supporting the adherence commitment been attached?

☐ Yes ☐ No

Q47. Additional Information:

Prescriber Signature

Date

Updated for 2020