# HEPATITIS C AGENTS PRIOR AUTHORIZATION FORM

(form effective 1/1/20)

Keystone First | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-215-937-5018**, or to speak to a representative call **1-800-588-6767**.

## PRIOR AUTHORIZATION REQUEST INFORMATION

| ☐ New request ☐ Renewal request | total # pages: | Name/phone # of office contact: |
|---|---|---|

## PATIENT INFORMATION

| Patient name: | Patient ID #: | DOB: |
|---|---|---|
| Street address: | Apt. #: | City/state/zip: |

## PRESCRIBER INFORMATION

| Prescriber name: | State license #: | NPI: |
|---|---|---|
| Street address: | Suite #: | City/state/zip: |
| Phone: | Fax: | |

## CLINICAL INFORMATION

**Medication(s) requested: (check all that apply to request — all agents listed require prior auth):**

| | | | |
|---|---|---|---|
| ☐ Copegustab (NP) | ☐ Ledipasvir-Sofosbuvir (NP) | ☐ Ribasphere Ribapak (NP) | ☐ Sovaldi (NP) |
| ☐ Daklinza (NP) | ☐ Mavyret[PA] | ☐ Ribasphere tablet (NP) | ☐ Viekira Pak (NP) |
| ☐ Epclusa (NP) | ☐ Moderiba tab (NP) | ☐ Ribavirin capsule[PA] | ☐ Viekira XR (NP) |
| ☐ Harvoni (NP) | ☐ Peg-Intron (NP) | ☐ Ribavirin tablet (NP) | ☐ Vosevi (NP) |
| ☐ Pegasys (NP) | ☐ Rebetol (NP) | ☐ Sofosbuvir-Velpatasvir[PA] | |

_____

(NP) denotes agent is non-preferred; *[PA] denotes an agent is preferred and requires a clinical prior authorization.

| Dose/directions: | | |
|---|---|---|
| Quantity | Refills: | Patient weight: |
| Diagnosis: | | Dx code *(required)*: |

**PHARMACY INFORMATION** (Prescriber to identify the pharmacy that is to dispense the medication)**:**

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:

Pharmacy Phone #:_____ Pharmacy Fax #:_____

☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.

1. What is the patient's genotype? ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 Date of testing:_____ *Submit documentation of test results.*
2. What is the patient's baseline viral load? _____ Date of testing: _____ *Submit documentation of results within past 3 months.*
3. Does the patient have results of RAS (resistance-associated substitutions) testing? ☐ Yes – *Submit documentation of results.* ☐ No
4. Does the patient have results of recent kidney function testing? ☐ Yes – *Submit documentation of results.* ☐ No
5. What is the patient's Metavir fibrosis score?_____
6. Is the patient taking any medications that interact with the medication(s) being requested?☐ Yes ☐ No *Submit patient's complete medication list.*
7. Was the patient previously treated for hepatitis C? ☐ Yes ☐ No
   *Submit documentation of previous treatment regimen, treatment dates, lab work, and treatment outcome. Include results of NS5A RAS screening for all DAA treatment failures.*
8. Does the patient have a history of substance abuse or dependency? ☐ Yes ☐ No
   *Submit documentation of prescriber counseling regarding the risks of alcohol or IV drug abuse and an offer of a referral for substance use disorder treatment.*
9. Does the patient have documentation of receipt of the hepatitis B vaccination series or results of hepatitis B screening (HBsAg, anti-HBs, and anti-HBc)?
   ☐ Yes ☐ No *Submit documentation of vaccination or screening results.*
10. If positive for hepatitis B sAg (HBsAg), does the patient have results of quantitative HBV DNA testing? ☐ Yes ☐ No
    *Submit documentation of test results. If positive, submit plan for hep B treatment. If negative, submit plan for hep B vaccination.*
11. Does the patient have results of HIV screening (HIV Ag/Ab)? ☐ Yes – *Submit documentation of test results.* ☐ No
12. If confirmed positive by HIV-1/HIV-2 antibody differentiation immunoassay, is the patient being treated for HIV infection? ☐ Yes ☐ No
    *Submit documentation of HIV treatment or rationale for not treating.*
13. Does the patient have a life expectancy of less than 12 months due to non-liver-related comorbid conditions? ☐ Yes ☐ No
14. Does the patient have documented commitment to adherence with the planned course of treatment and monitoring by the prescriber? ☐ Yes ☐ No
    **Direct contact information for office hepatitis C contact (REQUIRED):**
    Name: _____
    Phone #: _____ Email: _____
15. Will the patient be taking ribavirin?
    ☐ Yes – *Submit documentation of CBC with differential (within past 3 months) and, if female, a recent negative pregnancy test and contraceptive measures that will be used.*
    ☐ No
16. For requests for NON-PREFERRED agents, has the patient tried and failed, or have a contraindication or intolerance to, the preferred agents listed below in the same drug class/type as the requested non-preferred agent?
    **Preferred direct acting antivirals:** ☐ Mavyret*[PA] ☐ Zepatier*[PA] ☐ Sofosbuvir-Velpatasvir
    **Preferred ribavirins:** ☐ ribavirin 200mg capsule
    ☐ Yes – *Submit documentation of contraindication, intolerance, or drug regimen tried and failed.* ☐ No

## PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

| Prescriber signature: | Date: |
|---|---|