Fax completed prior authorization request form to 877-309-8077 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

HEPATITIS C AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Hepatitis C Agents** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	total # pages: _____	Prescriber name:	
Office contact name/phone:		State license #:	NPI:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Requested drug #1:	Directions:	Qty:	Refills:
Requested drug #2:	Directions:	Qty:	Refills:

SUBMIT DOCUMENTATION from the medical record for all items below.

Genotype: Date of testing:		Baseline viral load: Date of testing:	
Beneficiary's complete medication list:			
Does the beneficiary have results of RAS (resistance-associated substitutions) testing?	☐Yes – *Submit documentation.* ☐No		
Does the beneficiary have results of recent kidney function tests and Metavir fibrosis score?	☐Yes – *Submit documentation.* ☐No		
Does the beneficiary have results of HIV screening (HIV Ag/Ab)?	☐Yes – *Submit documentation.* ☐No		
If confirmed positive by HIV-1/HIV-2 antibody differentiation immunoassay, is the beneficiary being treated for HIV infection?	☐Yes ☐No	*Submit documentation of HIV treatment or rationale for not treating.*	
Does the beneficiary 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.*	
If positive for hepatitis B sAg (HBsAg), does the beneficiary 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.*	
Was the beneficiary previously treated for hepatitis C?	☐Yes ☐No	*Submit documentation of previous regimen, dates, lab work, and treatment outcome. Include results of NS5A RAS screening for all DAA treatment failures.*	
Does the beneficiary have documented commitment to adherence with the planned course of treatment and mutual monitoring by the prescriber and the Department?	☐Yes ☐No	**Direct contact information for office hepatitis C contact (REQUIRED):** Name: _____ Phone #: _____ Email: _____	
Will the beneficiary 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		
For requests for NON-PREFERRED agents: Has the beneficiary tried and failed or have a contraindication or intolerance to the preferred Hepatitis C Agents? *Refer to https://papdl.com/preferred-drug-list for the list of preferred and non-preferred Hepatitis C Agents.*	☐Yes ☐No	*Submit documentation.*	

FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO AETNA PHARMACY 1-877-309-8077

Prescriber Signature:	**Date**:

C16641-A 08/2019 Effective: 01/01/2020