HEPATITIS C AGENTS PRIOR AUTHORIZATION FORM

(form effective 1/3/2022)

Keystone First Community HealthChoices | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-855-851-4058**, or to speak to a representative call **1-866-907-7088**.

Office contact name/phone:	Prescriber name:		
LTC facility contact/phone:	State license #:	NPI:	total # pages:
Street address:			Suite #:
City/state/zip:			
Beneficiary name:			
Beneficiary ID#:	DOB:	Phone:	Fax:
Requested drug #1:	Directions:		
Quantity:	☐ 8 weeks ☐ 12 weeks ☐ 16 weeks ☐ Other: _____		
Requested drug #2:	Directions:		
Quantity:	☐ 8 weeks ☐ 12 weeks ☐ 16 weeks ☐ Other: _____		
Is the beneficiary currently being treated with the requested drug?	☐ No ☐ Yes – Therapy start date: _____		

SUBMIT DOCUMENTATION from the medical record for all items below.

1. Baseline quantitative HCV RNA and date of testing.
2. Metavir fibrosis score documented by a recent noninvasive test and date of testing.
3. Genotype if one of the following (check the appropriate box for the beneficiary):
   - ☐ The beneficiary is prescribed a non-pangenotypic regimen.
   - ☐ The beneficiary is hepatitis C treatment experienced.
   - ☐ The beneficiary has decompensated cirrhosis.
   - ☐ The beneficiary is treatment-naïve (with cirrhosis) and prescribed sofosbuvir/velpatasvir.
4. RAS (resistance-associated substitutions) testing and date of testing if one of the following (check the appropriate box for the beneficiary):
   - ☐ The beneficiary is genotype 1a and prescribed elbasvir/grazoprevir.
   - ☐ The beneficiary is genotype 1a, treatment-experienced, and prescribed ledipasvir/sofosbuvir.
   - ☐ The beneficiary is genotype 3, treatment-naïve (with cirrhosis) or treatment-experienced (without cirrhosis), and prescribed 12 weeks of sofosbuvir/velpatasvir.
5. Results of HIV (HIV Ag/Ab) screening.
6. For requests for NON-PREFERRED agents, documentation that the beneficiary tried and failed or has a contraindication or intolerance to the preferred hepatitis C agents.

ATTESTATION from the prescriber for one of the items below.

Check the appropriate box for the beneficiary.

☐ The beneficiary is hepatitis C treatment naïve.

☐ The beneficiary has been treated for hepatitis C with the following treatment regimen:

Prescriber signature:	Date (MM/DD/YYYY): / /