UnitedHealthcare Community Plan

Hepatitis C Medications - Pennsylvania
PRIOR AUTHORIZATION REQUEST FORM

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Office contact name/phone:		Prescriber name:		
LTC facility contact/phone:		State license #:		NPI:
total # pages:		Street address:		
Beneficiary name:		Suite #:	City/state/zip:	
Beneficiary ID#:	DOB:	Phone:		Fax:
Requested drug #1:	Directions:		Qty:	☐ 8 weeks ☐ 16 weeks ☐ 12 weeks ☐ Other: _____
Requested drug #2:	Directions:		Qty:	☐ 8 weeks ☐ 16 weeks ☐ 12 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**: