pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

HEPATITIS C AGENTS

PRIOR AUTHORIZATION FORM

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

Office contact name/phone:		Prescriber name:		
LTC facility contact/phone:		State license #:	NPI:	
total # pages:		Street address:		
Beneficiary name:		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. Cirrhosis assessment 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:

_____

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date: