HEPATITIS C AGENTS
PRIOR AUTHORIZATION FORM
(form effective 1/1/20)

AmeriHealth Caritas Pennsylvania | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774.**

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

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

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: