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1. Complete all 3 (three) pages of this form. Incomplete forms will be returned.
2. Attach required genotype results and biopsy results or other fibrosis test results.
3. Return form and supporting documentation to 410-424-4607 or 410-424-4751.
4. Questions? Contact PP Pharmacy Review at 888-819-1043, option 4.

HEPATITIS C THERAPY PRIOR AUTHORIZATION FORM: Page 1 of 3

Patient Information

Recipient:		MA#:
Date of Birth:	Phone #:	Body Weight:

Treatment Plan

☐ Sovaldi ® (sofosbuvir) 400mg:	Take once daily for _____ weeks
☐ Olysio ® (simeprevir) 150mg:	Take once daily for _____ weeks
☐ Harvoni ®:	Take _____ tablet(s) once daily for _____ weeks
☐ Viekira Pak ™:	Take as directed for _____weeks
☐ Ribavirin _____ mg:	Take _____ in the morning
☐ Peginterferon alfa _____ mcg:	Inject once weekly for _____ weeks
☐ Daklinza™: _____mg:	Take once daily for _____weeks
☐ Technivie™:	Take 2 tablets once daily for _____weeks
☐ Zepatier™:	Take 1 tablet once daily for _____ weeks
☐ Epclusa®	Take 1 tablet once daily for _____ weeks
☐ _____:	Take _____ daily for _____ weeks

Adherence with prescribed therapy is a condition for payment of therapy for up to the allowed timeframe for each HCV genotype.

Has a treatment plan been developed and discussed with patient? ☐ No ☐ Yes

Does the patient have any history of medication non-adherence?
☐ No ☐ Yes; If yes, please explain:

Diagnosis

☐ Acute Hep C	☐ Chronic Hep C	☐ Hepatocellular Carcinoma
☐ Liver transplant recipient:	Genotype of pre-transplant liver: _____	
	Genotype of post-transplant liver: _____	

☐ Other: _____

What is the patient's HCV Genotype and subtype? _____

Has a liver biopsy been performed? ☐ No ☐ Yes; Test Date: _____/_____/_____

Has a fibrosis test been performed: ☐ No

☐ Yes; Test used: _____; Test Date: _____/_____/_____

Metavir Grade: _____; Metavir Stage: _____

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HEPATITIS C THERAPY PRIOR AUTHORIZATION FORM: Page 2 of 3

Please provide a copy of the results of the biopsy, genotype and any other fibrosis tests for this patient*

What best describes this patient's liver disease? (Check all that apply):

☐ No cirrhosis ☐ Compensated cirrhosis ☐ Decompensated liver disease

Hepatitis C Treatment History

Has this patient been treated for Hepatitis C in the past: ☐ Treatment Naïve ☐ Treatment Experienced

If treatment experienced, what was the outcome of the previous treatments:

☐ Relapsed ☐ Partial Responder ☐ Non-responder ☐ Toxicities

HCV Regimen	Treatment duration/dates	Treatment Outcome
		☐ Relapsed ☐ Partial Responder ☐ Non-responder ☐ Toxicities ☐ Other: _____
		☐ Relapsed ☐ Partial Responder ☐ Non-responder ☐ Toxicities ☐ Other: _____

Laboratory Results

Baseline HCV RNA level (within **75** days of treatment): _____ Date: _____/_____/_____

Baseline AST: _____ Baseline ALT: _____ Date: _____/_____/_____

Baseline hemoglobin: _____ Baseline Hematocrit: _____ Date: ____/_____/____

Baseline platelet: _____ Date: ____/_____/____

Medical History

Is the patient co-infected with HIV? ☐ No ☐ Yes; If yes, HIV viral load: _____
Date drawn: ____/_____/____

Has the patient had a solid organ transplant? ☐ No ☐ Yes;
If yes, specify type of transplant: _____ Date of transplant: ____/_____/____

Substance Use History

Does the patient have an active diagnosis of a substance use disorder? ☐ Yes ☐ No

If YES, is the patient actively engaged in treatment? ☐ Yes ☐ No

If NO, please indicate whether an adherence assessment has been done to assure successful treatment completion: ☐ Yes ☐ No

If the patient's Medicaid eligibility changes during therapy and the patient is no longer eligible for Medicaid prescription drug assistance, is the physician prepared to enroll the patient in other patient assisted drug programs to complete therapy? ☐ Yes ☐ No

I certify that the information provided is accurate. Supporting documentation is available for State audits.

_____ _____ _____

Prescriber Signature Prescriber Name Date

Practice Specialty: _____ Prescriber Phone: _____

Practice Address: _____ Prescriber Fax: _____

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Hepatitis C Treatment Plan: Page 3 of 3

Patient's Name: _____	DOB: _____

Genotype (including subtype): _____

Medications: Please indicate drugs, dose and duration:
(Take or use medications as directed, do not skip a dose)
☐ Harvoni ®: --Take _____ tablet(s) once daily for _____weeks
☐ Sovaldi ® (sofosbuvir) 400mg: – Take once daily for _____ weeks
☐ Viekira Pak ™: -Take as directed for _____ weeks
☐ Olysio ® (simeprevir) 150mg: – Take once daily for _____weeks
☐ Ribavirin_____ mg – Take _____ in the morning and _____ in the afternoon for
☐ Peginterferon alfa _____ mcg: -- Inject once weekly for _____ weeks
☐ Daklinza™ _____mg: --Take once daily for _____weeks
☐ Technivie ™ : --Take two tablets once daily for _____weeks
☐ Zepatier™:--Take once daily for _____weeks
☐ Epclusa®:--Take once daily for _____weeks
☐ Other:

Laboratory Testing – Indicate week during which labs should be completed
HCV levels must be obtained at Treatment weeks 4, 12 and 24 (if necessary)

Week 4 - _____ (please insert due date)
Week 12 - _____ (please insert due date)
Week 24 (if indicated) - _____ (please insert due date)
SVR upon completion of therapy - _____ (please insert due date)

HCV Genotype and Comorbidities	Treatment	Duration
Patients with genotype 1 HCV	sofosbuvir + peginterferon alfa + ribavirin **OR** simeprevir + peginterferon alfa + ribavirin	12 weeks **OR** 12 weeks of simeprevir and 24 to 48 weeks of peginterferon alfa + ribavirin
Patients with genotype 1 HCV and interferon ineligible	sofosbuvir + ribavirin	24 weeks
Patients with genotype 2 HCV	sofosbuvir + ribavirin	12 weeks
Patients with genotype 3 HCV	sofosbuvir + ribavirin	24 weeks
Patients with genotype 3 HCV, without cirrhosis	daclatasvir + sofosbuvir	12 weeks
Patients with genotype 4 HCV	sofosbuvir + peginterferon alfa + ribavirin	12 weeks
Patients with genotype 4 HCV	Ombitasvir/paritaprevir/ritonavir + ribavirin	12 weeks
Patients with hepatocellular carcinoma awaiting liver transplantation	sofosbuvir + ribavirin	48 weeks (or until the time of liver transplantation; whichever occurs first)

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This form is for provider's reference only and does not need to be returned to the health plan

HCV Prior Authorization Provider Checklist

Dear Provider,
In order to facilitate the approval of medications to treat your patient's HCV, please utilize the following checklist to ensure you have included all necessary documentation.

For start of treatment:

☐ Completed PA form

☐ Completed treatment plan (recommended not required for initial therapy

☐ Baseline lab values (within last 75 days)

☐ HCV genotype

☐ Fibrosis score documentation (fibrosure or biopsy results)

☐ Recent (within last 3 months) provider note

For refill authorization:

In order to continue on the HCV therapy, patient is required to have follow up labs.

☐ Lab values between 2 to 4 weeks after initiation of therapy

☐ Lab values after 12 weeks of therapy (for 24 week treatment)

In cases of retreatment, additional viral load values will be requested at week 2 and 6.