Hepatitis C Prior Authorization Request Form

Phone:(800) 303-9626
Fax:(844) 807-8455

PATIENT INFORMATION	PRESCRIBER INFORMATION
Full Name: _____	Full Name: _____
ID: _____	NPI #: _____
DOB_____	Specialty: _____
Phone: _____	Office Phone: _____
Allergies: _____	Office Fax: _____
	Office Address: _____

DIAGNOSIS INFORMATION

Indicate ALL drugs for this course of treatment:

☐ Mavyret (Plan preferred) ☐ Daklinza ☐ Epclusa ☐ Harvoni ☐ Olysio
☐ Sofosbuvir/Velpatasvir (generic Epclusa) ☐ Pegasys ☐ Ribavirin ☐ Sovaldi ☐ Technivie
☐ Ledipasvir/Sofosbuvir (generic Harvoni) ☐ Viekira Pak ☐ Viekira XR ☐ Vosevi ☐ Zepatier
☐ Other: _____

Dose:_____ **Frequency:** _____ **Anticipated Start Date:** _____
ICD-10: _____

Diagnosis: ☐ Chronic Hepatitis C ☐ Chronic hepatitis B, including HDV co-infection, *no further questions.*
☐ Myeloproliferative neoplasm (essential thrombocythemia, polycythemia vera, primary myelofibrosis and post-polycythemia vera or post-essential thrombocythemia myelofibrosis), *no further questions.*
☐ Other: _____

Is the patient currently receiving treatment with the requested drug? ☐ Yes ☐ No *If Yes,* Start Date: _____
Is the medication prescribed by, or in consultation with, a gastroenterologist, infectious disease specialist, or hepatologist? ☐ Yes ☐ No *If yes,* Specialist's Name:_____ Specialist's Office Phone: _____

CLINICAL INFORMATION

Does the patient have any of the following conditions?

☐ Moderate of severe hepatic impairment (Child Turcotte Pugh [CTP] class B or C)
☐ Decompensated cirrhosis (CTP class B or C)
☐ Patient has genotype 1 infection and has had an inadequate virologic response with a regimen containing both an NS5A inhibitor AND an NS3/4A protease inhibitor
☐ Patient has genotype 2,3,4,5, or 6 infection and has had an inadequate virologic response with a regimen containing an NS5A inhibitor or an NS3/4A protease inhibitor
☐ None of the above

Prior to treatment, has hepatitis C been confirmed by the presence of a viral load (HCV-RNA) in the serum?
☐ Yes ☐ No

Baseline viral load (HCV-RNA): _____ Date of lab week: _____
Genotype: _____ *If genotype 1, specify the subtype:* ☐ 1a ☐ 1b ☐ Mixed ☐ Unknown
Duration of therapy: _____ weeks
Planned start date (mm/dd/yyyy): _____
If patient has started this requested regimen, how long has the patient received therapy? _____ weeks

Indicate all that apply:

☐ HIV co-infection ☐ Hepatocellular carcinoma ☐ Awaiting liver transplantation ☐ African American
☐ Compensated cirrhosis ☐ Kidney transplant recipient ☐ Decompensated cirrhosis (CTP class B or C)
☐ Moderate or severe hepatic impairment (CTP class B or C) ☐ Recurrent HCV infection post liver transplantation
☐ Documented anemia – *Indicate **baseline** hemoglobin level :*_____g/dL
☐ Documented INTERFERON ineligibility – ***Reason:*** _____
☐ Ineligible/Intolerance to receive ribavirin – ***Reason:*** _____

*****Documentation including chart-notes/lab works are required for prior authorization request*****

ADDITIONAL CLINICAL INFORMATION

Treatment status prior to requested regimen:

☐ Treatment-naïve

☐ Failed-prior treatment(s) – Please indicate regimen(s) and date(s) of treatment below.

Regimen 1:_____ Dates of treatment:_____

Regimen 2:_____ Dates of treatment:_____

☐ Other: _____

Complete the following section based on the prescribed regimen, if applicable.

Section A: Epclusa + Ribivirin **OR** Vosevi Monotherapy **OR** Daklinza + Sovaldi + Ribavirin:

If patient has **genotype 3,** has laboratory testing for presence of NS5A inhibitor resistance-associated substitutions been performed? ☐ Yes ☐ No ☐ Not applicable ☐ New start

Was the Y93H substitution associated with velpatasvir resistance detected? ☐ Yes ☐ No

If *Daklinza + Sovaldi +/- ribavirin is being prescribed,* was the Y93H substitution associated with daclatasvir resistance detected? ☐ Yes ☐ No

Section B: Olysio + Pegasys + Ribavirin OR Sovaldi + Olysio:

If patient has **genotype 1a,** is the NS3 Q80K polymorphism present? ☐ Yes ☐ No ☐ Unknown

If *Olysio + Pegasys + Ribavirin* is being prescribed, did the patient have HCV-RNA **less than 25IU/ml** at week 4 of treatment? ☐ Yes ☐ No ☐ Not applicable ☐ New start

Section C: Sovaldi + Ribavirin:

Does the patient meet the MILAN criteria?

A) Tumor size 5cm or less in diameter with single hepatocellular carcinomas OR 3 tumor nodules or less, each 3cm or less in diameter with multiple tumors ☐ Yes ☐ No

AND

B) No extrahepatic manifestations of the cancer of evidence of vascular invasion of tumor. ☐ Yes ☐ No

Section D: Viekira Pak/Viekira XR + Ribavirin:

What is the patient's Metavir fibrosis score? ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4 ☐ Other

Section E: Zepatier +/- Ribavirin – **Genotype 1**

Does the patient have end-stage renal disease (ESRD) or severe renal impairment (estimated glomerular filtration rate [eGFR] of less than 30mL/min/1.73m^2)? ☐ Yes ☐ No

Was the patient tested for baseline NS5A resistance-associated substitutions (RASs)/polymorphisms? ☐Yes ☐No

Is one or more baseline NS5A resistance-associated substitutions (RASs)/polymorphisms present? ☐Yes ☐No

*****Documentation including chart-notes/lab works are required for prior authorization request*****

I attest that this information is accurate and true, and that documentation supporting this information was attached and is available for review if requested by MetroPlus Health Plan.

X _____ _____

Prescriber or Authorized Signature **Date (mm/dd/yyyy)**

OFFICE CONTACT: _____ **Phone:** _____ **EXT:** _____

Date Form Completed and Faxed: _____

MetroPlus Health Plan

Pharmacy Utilization Management Department

160 Water Street 3rd floor, New York, NY 10038

Tel: 1-800-303-9626

Fax: 1-844-807-8455