

# HEPATITIS C AGENTS PRIOR AUTHORIZATION FORM

(form effective 1/1/20)



Keystone First

**PERFORMRx**<sup>SM</sup>  
Next Generation Pharmacy Benefits

Fax to PerformRx<sup>SM</sup> at **1-215-937-5018**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION			
<input type="checkbox"/> New request	<input type="checkbox"/> 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		
<b>Medication(s) requested: (check all that apply to request — all agents listed require prior auth):</b>		
<input type="checkbox"/> Copegustab (NP)	<input type="checkbox"/> Ledipasvir-Sofosbuvir (NP)	<input type="checkbox"/> Ribasphere Ribapak (NP)
<input type="checkbox"/> Daklinza (NP)	<input type="checkbox"/> Mavyret <sup>PA</sup>	<input type="checkbox"/> Ribasphere tablet (NP)
<input type="checkbox"/> Epclusa (NP)	<input type="checkbox"/> Moderiba tab (NP)	<input type="checkbox"/> Ribavirin capsule <sup>PA</sup>
<input type="checkbox"/> Harvoni (NP)	<input type="checkbox"/> Peg-Intron (NP)	<input type="checkbox"/> Ribavirin tablet (NP)
<input type="checkbox"/> Pegasys (NP)	<input type="checkbox"/> Rebetol (NP)	<input type="checkbox"/> Sofosbuvir-Velpatasvir <sup>PA</sup>
<input type="checkbox"/> Sovaldi (NP)		
<input type="checkbox"/> Viekira Pak (NP)		
<input type="checkbox"/> Viekira XR (NP)		
<input type="checkbox"/> Vosevi (NP)		
<input type="checkbox"/> _____		
(NP) denotes agent is non-preferred; <sup>PA</sup> denotes an agent is preferred and requires a <u>clinical</u> prior authorization.		
Dose/directions:		
Quantity	Refills:	Patient weight:
Diagnosis:		Dx code (required):

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):	
Deliver to: <input type="checkbox"/> Patient's Home	<input type="checkbox"/> Physician's Office
<input type="checkbox"/> Patient's Preferred Pharmacy Name:	
Pharmacy Phone #:	Pharmacy Fax #:
<input type="checkbox"/> I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.	

1. What is the patient's genotype? <input type="checkbox"/> 1a <input type="checkbox"/> 1b <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 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? <input type="checkbox"/> Yes – Submit documentation of results. <input type="checkbox"/> No
4. Does the patient have results of recent kidney function testing? <input type="checkbox"/> Yes – Submit documentation of results. <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Submit patient's complete medication list.
7. Was the patient previously treated for hepatitis C? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes – Submit documentation of test results. <input type="checkbox"/> No
12. If confirmed positive by HIV-1/HIV-2 antibody differentiation immunoassay, is the patient being treated for HIV infection? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
14. Does the patient have documented commitment to adherence with the planned course of treatment and monitoring by the prescriber? <input type="checkbox"/> Yes <input type="checkbox"/> No Direct contact information for office hepatitis C contact (REQUIRED): Name: _____ Phone #: _____ Email: _____
15. Will the patient be taking ribavirin? <input type="checkbox"/> 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. <input type="checkbox"/> 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: <input type="checkbox"/> Mavyret <sup>PA</sup> <input type="checkbox"/> Zepatier <sup>PA</sup> <input type="checkbox"/> Sofosbuvir-Velpatasvir Preferred ribavirins: <input type="checkbox"/> ribavirin 200mg capsule <input type="checkbox"/> Yes – Submit documentation of contraindication, intolerance, or drug regimen tried and failed. <input type="checkbox"/> No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION	
Prescriber signature:	Date:

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