HEPATITIS C AGENTS PRIOR AUTHORIZATION FORM

(form effective 1/5/21)

Keystone First | PERFORMRx℠ Next Generation Pharmacy Benefits

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

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):

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

(NP) denotes agent is non-preferred; *PA denotes an agent is preferred and requires a clinical 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: ☐ 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 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.*
9. 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.
10. Does the patient have results of HIV screening (HIV Ag/Ab)? ☐ Yes – *Submit documentation of test results.* ☐ No
11. 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.
12. Does the patient have a life expectancy of less than 12 months due to non-liver-related comorbid conditions? ☐ Yes ☐ No
13. 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: _____
14. 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
15. 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:

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