Prior Authorization Request Form for Hepatitis C Agents

FAX this completed form to (844) 205-3386

OR Mail requests to: PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

Office contact name/phone:		Prescriber name:		
LTC facility contact/phone:		State license #:	NPI:	
Total # pages:		Street address:		
Member name:		City/state/zip:		
Member ID#:	DOB:	Phone:	Fax:	
Requested drug #1:	Directions:	Qty:	☐ 8 weeks ☐ 16 weeks ☐ 12 weeks ☐ Other: _____	
Requested drug #2:	Directions:	Qty:	☐ 8 weeks ☐ 16 weeks ☐ 12 weeks ☐ Other: _____	
Is the member currently being treated with the requested drug?		☐ No ☐ Yes – Therapy start date: _____		

SUBMIT DOCUMENTATION from the medical record for all items below.

For requests for NON-PREFERRED Hepatitis C Agents:

1. Documentation that the member tried and failed or has a contraindication or intolerance to the preferred Hepatitis C Agents. *(See the Preferred Drug List for the list of preferred Hepatitis C Agents at: https://papdl.com/preferred-drug-list.)*
2. Cirrhosis assessment documented by a recent noninvasive test and date of testing.
3. Genotype if one of the following (check the appropriate box for the member):
   - ☐ The member is prescribed a non-pangenotypic regimen.
   - ☐ The member is hepatitis C sofosbuvir-based, sofosbuvir/velpatasvir/voxilaprevir, or sofosbuvir plus glecaprevir/pibrentasvir treatment experienced.
   - ☐ The member has decompensated cirrhosis and is prescribed ledipasvir/sofosbuvir.
   - ☐ The member is treatment-naïve (with cirrhosis) and prescribed sofosbuvir/velpatasvir.
4. RAS (resistance-associated substitutions) testing and date of testing if one of the following (check the appropriate box for the member):
   - ☐ The member is genotype 1a and prescribed elbasvir/grazoprevir.
   - ☐ The member is genotype 1a, treatment-experienced, and prescribed ledipasvir/sofosbuvir.
   - ☐ The member is genotype 3, treatment-naïve (with cirrhosis) or treatment-experienced (without cirrhosis) and prescribed 12 weeks of sofosbuvir/velpatasvir.

For requests for THERAPEUTIC DUPLICATION of Hepatitis C Agents direct-acting antivirals (DAAs):

For a member taking more than 1 Hepatitis C Agents DAA product concomitantly:

- ☐ The member has a medical reason for concomitant use of the requested products that is supported by peer-reviewed medical literature or national treatment guidelines.

ATTESTATION from the prescriber for one of the items below.

Check the appropriate box for the member.

- ☐ The member is hepatitis C treatment naïve.
- ☐ The member has been treated for hepatitis C with the following treatment regimen: _____

_____

ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO (844) 205-3386

Prescriber Signature:	**Date**:

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PA Department will respond via fax or phone within 24 hours.

Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)