pa health & wellness

Prior Authorization Request Form for Hepatitis C Agents

FAX this completed form to (844) 205-3386

OR Mail requests to: Pharmacy 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:		Suite #:	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.

1. Baseline quantitative HCV RNA and date of testing.
2. Metavir fibrosis score 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 treatment experienced.
   - ☐ The member has decompensated cirrhosis.
   - ☐ 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.
5. Results of HIV (HIV Ag/Ab) screening.
6. For requests for NON-PREFERRED agents, documentation that the member tried and failed or has a contraindication or intolerance to the preferred Hepatitis C Agents.

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:

_____

Prescriber Signature:	**Date**:

Pharmacy 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.)