HEPATITIS C AGENTS PRIOR AUTHORIZATION FORM

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

Prior authorization guidelines for **Hepatitis C Agents** and **Quantity Limits/Daily Dose Limits** are available on the the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html.

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(s)?	☐ Yes – Therapy start date: _____		☐ No	

SUBMIT DOCUMENTATION from the medical record for all items below.

For requests for NON-PREFERRED Hepatitis C Agents direct-acting antivirals (DAAs):

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.

For requests for ALL OTHER NON-PREFERRED Hepatitis C Agents (e.g., Pegasys): Diagnosis: _____

☐ The member has a history of therapeutic failure of or a contraindication or an intolerance to first line therapies.

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: _____

pa health & wellness™

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

Prescriber Signature:	**Date**:

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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.)