WellCare Health Plans

PRIOR AUTHORIZATION REQUEST FORM FOR HEPATITIS C TREATMENT

Instructions: Please complete ALL FIELDS and FAX COMPLETED FORM TO 1-888-340-9512.

Member Name		Prescriber FULL Name/Specialty
Member ID #	Date of Birth	Prescriber NPI
Member's Telephone Number		Office Address
Diagnosis of chronic hepatitis C ☐ Yes ☐ No		
Genotype		Office Phone #
Does the patient have decompensated liver disease? ☐ Yes ☐ No		Office Fax #

REQUESTED MEDICATION(S)

Drug Name	Drug Strength	Drug Dosage Form	Drug Dosing	Length of Treatment

New start or a continuation of therapy? ☐ New start ☐ Continuation Start Date_____

Previous therapies used to treat hepatitis C

Drug & Dose Used	Start Date	Stop Date	Therapeutic Outcome

****REQUIRED DOCUMENTATION – Please submit all required clinical notes/lab reports in reference to this request.****

- If awaiting liver transplant, is the patient suitable for transplant per Milan criteria? ☐ Yes ☐ No
- **Substance or alcohol use:** Patients with active substance or alcohol use disorders should be considered for therapy on a case-by-case basis, and care should be coordinated with substance use treatment specialists.

Child Pugh Score: _____ Total Serum Bilirubin: _____

Albumin: _____ INR: _____ CrCl: _____

Post liver transplant: ☐ Yes ☐ No

Ascites: ☐ Yes ☐ No

Type 2 or 3 mixed cryoglobulinemia: ☐ Yes ☐ No

Proteinuria, nephrotic syndrome, or membranoproliferative glomerulonephritis: ☐ Yes ☐ No

Hepatic encephalopathy: ☐ Yes ☐ No

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Hepatitis B positive: ☐ Yes ☐ No

Human Immunodeficiency Virus (HIV) positive: ☐ Yes ☐ No

If yes, is member on stable ARV treatments? ☐ Yes ☐ No

The following document submissions are required for review:	**Check off the following items that have been completed:**
1) HCV-RNA viral load labs within the past 90 days 2) Urine toxicology within the past 30 days 3) Fibrosis score results (Metavir, Ishak, Apri, FibroSure, FibroScan) 4) Listed name of the specialty pharmacy to fill the medication 5) Most recent complete blood count (CBC) 6) CD4 labs within the previous 90 days if co-infected with HIV-1 7) Current antiretroviral regimen if co-infected with HIV-1	☐ Patient has been given an explanation of the importance of adherence, and has agreed to adhere to and complete the drug regimen as prescribed. ☐ Risks of hepatotoxic drugs including acetaminophen have been explained to the patient. ☐ Review of all non-Hepatitis C concurrent medications to determine interaction risk.

☐ **REQUEST FOR EXPEDITED REVIEW**

By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

By signing below, you attest that all statements on this form are true to the best of your knowledge.

Prescriber's Signature_____**Date**_____