



**PRIOR AUTHORIZATION REQUEST FORM FOR HEPATITIS C TREATMENT**

**Instructions: Please complete ALL FIELDS and FAX COMPLETED FORM TO 1-866-388-1517.**

Member Name		Prescriber FULL Name/Specialty		
Member ID #	Date of Birth	Prescriber NPI		
Member's Telephone Number		Office Address		
Diagnosis of chronic hepatitis C <input type="checkbox"/> Yes <input type="checkbox"/> No				
Genotype		Office Phone #		
Does the patient have decompensated liver disease? <input type="checkbox"/> Yes <input type="checkbox"/> No		Office Fax #		
<b>REQUESTED MEDICATION(S)</b>				
<b>Drug Name</b>	<b>Drug Strength</b>	<b>Drug Dosage Form</b>	<b>Drug Dosing</b>	<b>Length of Treatment</b>
New start or a continuation of therapy? <input type="checkbox"/> New start <input type="checkbox"/> Continuation      Start Date _____				
<b>Previous therapies used to treat hepatitis C</b>				
<b>Drug &amp; Dose Used</b>	<b>Start Date</b>	<b>Stop Date</b>	<b>Therapeutic Outcome</b>	
<b>**REQUIRED DOCUMENTATION – Please submit all required clinical notes/lab reports in reference to this request.**</b>				
<ul style="list-style-type: none"> <li>• If awaiting liver transplant, is the patient suitable for transplant per Milan criteria? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>• <b>Substance or alcohol use:</b> 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.</li> </ul>				
<b>Child Pugh Score:</b> _____ <b>Total Serum Bilirubin:</b> _____ <b>Albumin:</b> _____ <b>INR:</b> _____ <b>CrCl:</b> _____ <b>Post liver transplant:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Ascites:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Hepatic encephalopathy:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Hepatitis B positive:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Human Immunodeficiency Virus (HIV) positive:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				

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

**The following document submissions are required for review:**

- 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

**Check off the following items that have been completed:**

- 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.

**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 \_\_\_\_\_