UnitedHealthcare Community Plan

Hepatitis C Medications – Hawaii
PRIOR AUTHORIZATION REQUEST FORM

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

- Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: _____
- Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Physician Information

First Name:		Last Name:	M.D./D.O.
Address:		City:	State: ZIP code:
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax attention to:			

Section C - Medical Information (***This form is for Hepatitis C Medications only; for all other drugs please submit a new form)***

□ **Ribavirin Product Requested (Include Strength):**	**Ribavirin Directions of Use:**
□ **Inferferon Product Requested (Include Strength):**	**Interferon Directions of Use:**
□ **Sovaldi**	**Sovaldi Directions of Use:**
□ **Olysio**	**Olysio Directions of Use:**
□ **Zepatier** □ **Epclusa** □ **Mavyret**	**Directions of Use:**
□ **Victrellis** □ **Incivek** □ **Other Agent**	**Directions of Use:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS WITH HEPATITIS C
All supporting labs and chart documentation is required for medical review of this request.

Genotype (Must submit supporting lab documentation)
□ Gentoype 1 □ Gentoype 2 □ Gentoype 3 □ Gentoype 4 □ Gentoype 5 □ Gentoype 6
□ Other Gentoype (Must Specify): _____

Prescriber Specialty:
□ **Hepatologist** □ **Gastroenterologist** □ **Infectious Disease Specialist** □ **HIV Specialist**
□ **Other (Must Specify):** _____

- Has this patient been treated for Hepatitis C previously? □ Yes □ No
If "Yes", please provide details of previous therapy including names of medications used, dates of therapy, and outcome of treatment / reason for discontinuing: _____
_____

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Member First name:	Member Last name:	Member DOB:

Section D – Previous Medication Trials

Trial	Regimen (*List all medications tried with each trial)*	Dates of Therapy	Treatment Complete	Outcome of Treatment or Reason for Discontinuation
1				
2				
3				

Clinical and Drug Specific Information

*****Please Note: All labs and/or medical records addressed below MUST be submitted*****

- Does the patient have chronic HCV infection and a baseline quantitative HCV ribonucleic acid (RNA) result within the previous six months? □ Yes □ No If Yes, List HCV RNA and date: _____

- Does the patient meet at least one of the following criteria: □ Yes □ No (check all that apply)
- □ Metavir fibrosis score of F1 or greater
- □ Radiologic or clinical evidence of cirrhosis (e.g., evidence of portal hypertension, ascites, esophageal varices)
- □ Patients who meet any criteria below may be treated at any stage:
  - □ Coinfection with HIV and/or chronic hepatitis B virus (HBV)
  - □ Healthcare worker with direct patient contact
  - □ Women of childbearing age
  - □ HCV induced renal disease
  - □ Candidate for solid organ or stem cell transplantation
  - □ Extrahepatic manifestations of chronic HCV, such as cryoglobulinemia

- Does the patient have a history of alcohol or other substance abuse within the past 3 months prior to treatment as evidenced by history and urine toxicology screen? □ Yes □ No (MUST submit urine toxicology screen)

- Did the prescribing physician attest that the patient is at low risk for non-compliance? □ Yes □ No

- Does the patient demonstrate good compliance and agrees to the following? □ Yes □ No (check which apply)
- □ 100% medication compliance
- □ Regular follow up with specialty pharmacy, treating providers, and laboratory blood draws, such as HCV RNA levels, when ordered
- □ No active alcohol or substance abuse
- □ Compliant with drug screening such as urine toxicology screen when ordered by provider

- Are all medical conditions that may impact adherence (including mental health conditions and substance abuse) well controlled prior to starting treatment? □ Yes □ No

- Does the patient have any of the following limitations/exclusions:
- □ Chronic decompensated liver disease as defined by Child-Pugh > 6 (class B or class C), with exception for a patient who is an active candidate for liver transplantation
- □ Hepatocellular carcinoma, with exception for a patient who is an active candidate for liver transplantation

- Does the patient have a history of intolerance or contraindication to Mavyret? □ Yes □ No
(If yes, complete Section D above with medication information, duration, date of trial, and reason for discontinuation)

- Is the patient currently on any of the following medications: □ Yes □ No (check which applies)
□ Daklinza □ Epclusa □ Harvoni □ Olysio □ Sovaldi □ Technivie □ Viekira Pak
□ Viekira XR □ Vosevi □ Zepatier

- Please select one of the following: □ Compensated □ Decompensated □ Patient does not have cirrhosis

- What is the duration of treatment: □ 8 weeks □ 12 weeks □ 16 weeks □ 24 weeks □ Other, list _____ weeks

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- Is the patient post-transplant? □ Yes □ No

Requests for Mavyret:

- Is the patient without cirrhosis or has compensated cirrhosis (Child-Pugh A)? □ Yes □ No

- Which of the following does the patient have? □ Yes □ No (check which applies)

□ Genotype 1, 2, 3, 4, 5, or 6 and treatment naïve

□ Genotype 1 and treatment-experienced (previously treated) with an NS5A inhibitor without prior treatment with an NS3/4A protease inhibitor

□ Genotype 1 and treatment-experienced (previously treated) with an NS3/4A protease inhibitor without prior treatment with an NS5A inhibitor

□ Genotype 1, 2, 3, 4, 5, or 6 and treatment-experienced (previously treated) with interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A protease inhibitor or NS5A inhibitor

□ None of the above, **List regimen, duration, and condition:** _____

_____

_____

Requests for Daklinza:

- Is the request for one of the following? □ Yes □ No (check which applies)

□ Patient without cirrhosis, for Daklinza + sofosbuvir for 12 weeks

□ Patient with compensated (Child-Pugh A) cirrhosis, for Daklinza + sofosbuvir for 12 weeks

□ Patient with decompensated (Child-Pugh B or C) cirrhosis, for Daklinza + sofosbuvir + ribavirin for 12 weeks

□ Patient who is post-transplant, for Daklinza + sofosbuvir + ribavirin for 12 weeks

□ Patient with compensated (Child-Pugh A) cirrhosis, for Daklinza + sofosbuvir + ribavirin for 12 weeks

□ None of the above, **List regimen, duration, and condition:** _____

_____

_____

Requests for Epclusa:

- Is the request for one of the following? □ Yes □ No (check which applies)

□ Patient without cirrhosis, for Epclusa for 12 weeks

□ Patient with compensated cirrhosis (Child-Pugh A), for Epclusa for 12 weeks

□ Patient with decompensated cirrhosis (Child-Pugh B or C), for Epclusa + ribavirin for 12 weeks

□ None of the above, **List regimen, duration, and condition:** _____

_____

_____

Requests for Harvoni:

- What is the patient's weight?: _____ kg *(Required)*

- Is the request for one of the following? □ Yes □ No (check which applies)

□ Genotype 1 treatment-naïve without cirrhosis or with compensated cirrhosis (Child-Pugh A), for Harvoni x 12 weeks

□ Genotype 1 treatment-experienced without cirrhosis, for Harvoni x 12 weeks

□ Genotype 1 treatment-experienced with compensated cirrhosis (Child-Pugh A), for Harvoni x 24 weeks

□ Genotype 1 treatment-naïve or treatment-experienced with decompensated cirrhosis (Child-Pugh B or C), for Harvoni + ribavirin x 12 weeks

□ Genotype 1 or 4 treatment-naïve or treatment-experienced with liver transplant without cirrhosis, or with compensated cirrhosis (Child-Pugh A), for Harvoni + ribavirin x 12 weeks

□ Genotype 4, 5, or 6 treatment-naïve or treatment-experienced without cirrhosis or with compensated cirrhosis, for Harvoni x 12 weeks

□ None of the above, **List regimen, duration, and condition:** _____

_____

_____

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Requests for Olysio:

- Is the request for one of the following? □ Yes □ No (check which applies)

□ Genotype 1 without cirrhosis, for Olysio and sofosbuvir x 12 weeks

□ Genotype 1 with compensated cirrhosis (Child-Pugh A), for Olysio and sofosbuvir x 24 weeks

□ Genotype 1 or 4 without cirrhosis or with compensated cirrhosis (Child-Pugh A) with or without HIV-1 co-infection, for Olysio and Peg-IFN-alfa and ribavirin x 12 weeks

□ None of the above, **List regimen, duration, and condition:** _____

_____

_____

Requests for Sovaldi:

- What is the patient's weight?: _____ kg *(Required)*

- Is the request for one of the following? □ Yes □ No (check which applies)

□ Genotype 1 or 4, treatment naïve without cirrhosis or with compensated cirrhosis (Child-Pugh A), for Sovaldi + peg-interferon alfa + ribavirin x 12 weeks

□ Genotype 2, treatment naïve or treatment experienced without cirrhosis or with compensated cirrhosis (Child-Pugh A), for Sovaldi + ribavirin x 12 weeks

□ Genotype 3, treatment naïve or treatment experienced without cirrhosis or with compensated cirrhosis (Child-Pugh A), for Sovaldi + ribavirin x 24 weeks

□ Genotype 1 and interferon ineligible, for Sovaldi + ribavirin x 24 weeks,
List reason for interferon ineligibility: _____

_____

□ Hepatocellular carcinoma awaiting liver transplantation, for Sovaldi + ribavirin x up to 48 weeks or until liver transplantation, whichever occurs first, List date of liver transplant:

□ None of the above, **List regimen, duration, and condition:** _____

_____

_____

Requests for Technivie:

- Is the request for one of the following? □ Yes □ No (check which applies)

□ Patient without cirrhosis or with compensated cirrhosis, for Technivie + ribavirin x 12 weeks

□ Treatment naïve patient who cannot take or tolerate ribavirin, for Technivie x 12 weeks,
List ribavirin intolerance or contraindication: _____

□ None of the above, **List regimen, duration, and condition:** _____

_____

_____

Requests for Vosevi:

- Is the patient without cirrhosis or has compensated cirrhosis (Child-Pugh A)? □ Yes □ No

- Has the patient been previously treated with an NS3/4A inhibitor? □ Yes □ No

- Which of the following applies to the patient? □ Yes □ No (check which applies)

□ Genotype 1 and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing an NS5A inhibitor

□ Genotype 2, 3, 4, 5, or 6, and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing an NS5A inhibitor

□ Genotype 1a, and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing sofosbuvir without an NS5A inhibitor

□ Genotype 3, and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing sofosbuvir without an NS5A inhibitor.

□ None of the above, **List regimen, duration, and condition:** _____

_____

_____

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Requests for Viekira:

- Is the request for one of the following? □ Yes □ No (check which applies)

□ Genotype 1a without cirrhosis, for Viekira + ribavirin for 12 weeks
□ Genotype 1a with compensated cirrhosis, for Viekira + ribavirin x 24 weeks.
□ Genotype 1b, with or without compensated cirrhosis, for Viekira x 12 weeks
□ None of the above, **List regimen, duration, and condition:** _____

_____

_____

Requests for Zepatier:

- Is the request for one of the following? □ Yes □ No (check which applies)

□ Genotype 1a treatment-naïve or PegIFN/RBV experienced without baseline NS5A polymorphisms*, for Zepatier x 12 weeks
□ Genotype 1a treatment-naïve or PegIFN/RBV experienced with baseline NS5A polymorphisms*, for Zepatier + ribavirin x 16 weeks
□ Genotype 1b treatment-naïve or PegIFN/RBV experienced, for Zepatier x 12 weeks
□ Genotype 1a or 1b PegIFN/RBV/NS3/4A protease inhibitor experienced, for Zepatier + ribavirin x 12 weeks
□ Genotype 4 treatment naïve, for Zepatier x 12 weeks
□ Genotype 4 PegIFN/RBV experienced, for Zepatier + ribavirin x 16 weeks
□ None of the above, **List regimen, duration, and condition:** _____

_____

_____

Physician Signature: _____ **Date:** _____