

MASSACHUSETTS STANDARD FORM FOR HEPATITIS C MEDICATION PRIOR AUTHORIZATION REQUESTS

**Some plans might not accept this form for Medicare or Medicaid requests.*

A. Destination	
Health Plan or Prescription Plan Name: Optum Rx	
Health Plan Phone: 1-800-711-4555	Health Plan Fax: 1-844-403-1027

B. Patient Information		
Patient Name:	DOB:	Member ID #
Sex assigned at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> "X" or Intersex		
Current Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Other		
Plans do not discriminate based on race, color, national origin, age, disability, religion, creed, sexual orientation, or sex (including gender identity and gender stereotyping).		

C. Prescriber Information	
Prescribing Clinician:	Phone #:
Specialty:	Secure Fax #:
NPI #:	DEA #:
Prescriber Point of Contact Name (POC) (if different than prescriber):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
Prescribing Clinician or Authorized Representative Signature:	
Date:	

D. Medication Information
Check if Expedited Review/Urgent Request: <input type="checkbox"/> (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request as defined by the carrier.)
<input type="checkbox"/> Daklinza <input type="checkbox"/> Epclusa <input type="checkbox"/> Harvoni <input type="checkbox"/> Olysio <input type="checkbox"/> Ribavirin Generic <input type="checkbox"/> Ribavirin Branded <input type="checkbox"/> Sovaldi <input type="checkbox"/> Technivie <input type="checkbox"/> Viekira Pak <input type="checkbox"/> Viekira XR <input type="checkbox"/> Zepatier <input type="checkbox"/> Vosevi <input type="checkbox"/> Mavyret <input type="checkbox"/> Other _____
Requested Duration of Treatment: _____ weeks
Type of Therapy: <input type="checkbox"/> Initial <input type="checkbox"/> Continuation — weeks remaining: _____
Anticipated or actual start date: _____
Is the medication prescribed by, or in consultation with, a gastroenterologist, infectious disease specialist, or hepatologist? <input type="checkbox"/> Yes <input type="checkbox"/> No
For Zepatier only: Has there been confirmation that the patient does not have a genotype 1a with a baseline NSSA polymorphism? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
For Ribavirin only: Does the patient require a dosage form other than generic ribavirin 200 mg capsules or tablets? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify the following: Dosage form requested: _____ Clinical reason for use: _____
Are any of the following statements true? <input type="checkbox"/> Patient is pregnant or plans to become pregnant within 6 months of completing treatment <input type="checkbox"/> Patient is male with a female partner who is pregnant or plans to become pregnant within 6 months of completing treatment <input type="checkbox"/> Patient has contraindications or intolerance to Ribavirin

E. Patient Clinical Information

**Please refer to plan-specific criteria for details related to required information.*

Diagnosis: B18.2 Hepatitis C (chronic) Other: _____

HCV Genotype: 1 1a 1b 2 3 4 5 6

Stage of Hepatic Fibrosis: F0 F1 F2 F3 F4
 If F4: Compensated Decompensated

Check all methods of assessment that apply and include result:

Method	Result
<input type="checkbox"/> Liver biopsy	See above
<input type="checkbox"/> Transient elastography (FibroScan)	_____ kPa
<input type="checkbox"/> Shear wave elastography	_____ kPa
<input type="checkbox"/> MRE	_____ kPa
<input type="checkbox"/> FibroSure (FibroTest)	_____
<input type="checkbox"/> Echosens Fibrometer	_____
<input type="checkbox"/> Fibrospect	_____
<input type="checkbox"/> APRI	_____
<input type="checkbox"/> Fib-4	_____
<input type="checkbox"/> Hepascore	_____
<input type="checkbox"/> Other: _____	_____

Does the patient have HIV coinfection? Yes No Unknown

Is the patient status post liver transplant? Yes No

Confirm the patient's GFR range: 0-14 15-29 30 or greater (Please specify) _____

HCV RNA levels:

Baseline (most recent): _____ IU/mL Date of lab work: _____

Week 8 of treatment (if continuation request): _____ IU/mL Date of lab work: _____

Previous Treatments

Has the patient been previously treated for Hepatitis C and failed treatment? Yes No

Adverse Reaction? Yes No

Drug Name	Date of treatment (MM/YY)	Response to treatment
		<input type="checkbox"/> Relapsed <input type="checkbox"/> Partial response <input type="checkbox"/> Null response (<2 log reduction in HCV RNA at Week 12) <input type="checkbox"/> Did not complete <input type="checkbox"/> Briefly describe details: _____
		<input type="checkbox"/> Relapsed <input type="checkbox"/> Partial response <input type="checkbox"/> Null response (<2 log reduction in HCV RNA at Week 12) <input type="checkbox"/> Did not complete <input type="checkbox"/> Briefly describe details: _____
		<input type="checkbox"/> Relapsed <input type="checkbox"/> Partial response <input type="checkbox"/> Null response (<2 log reduction in HCV RNA at Week 12) <input type="checkbox"/> Did not complete <input type="checkbox"/> Briefly describe details: _____

Additional information pertinent to this request:

F. Exceptions to Step Therapy

Please complete the applicable section(s).

Is the alternative drug required under the step therapy protocol contraindicated, or will likely cause an adverse reaction in, or physical or mental harm to the member? Yes No

If yes, briefly describe details of contraindication, adverse reaction, or harm:

Is the alternative drug required under the step therapy protocol expected to be ineffective based on the known clinical characteristics of the member and the known characteristics of the alternative drug regimen? Yes No

If yes, briefly describe details of known clinical characteristics of member and alternative drug regimen.

Has the member previously tried the alternative drug required under the step therapy protocol, or another alternative drug in the same pharmacologic class or with the same mechanism of action, and such alternative drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No

If yes, please provide details for the previous trial:

Drug Name:

Dates/duration of use:

Did the member experience any of the following? Adverse reaction Inadequate response

Briefly describe details of adverse reaction or inadequate response:

Drug Name:

Dates/duration of use:

Did the member experience any of the following? Adverse reaction Inadequate response

Briefly describe details of adverse reaction or inadequate response:

Is the member stable on the requested prescription drug prescribed by the health care provider, and switching drugs will likely cause an adverse reaction in or physical or mental harm to the member? Yes No

If yes, briefly provide details on the member's stability and the likely adverse reaction or physical or mental harm:

*Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form.
Providers may attach any additional data relevant to medical necessity criteria.*