PRIOR AUTHORIZATION REQUEST: Hepatitis C Treatment

Please fax form to Amida Care: 1-646-786-0997

MEMBER INFORMATION	
Name:	Amida Care ID #:
Phone #:	Address:
PRESCRIBER INFORMATION	
Name:	NPI:
Office Phone #:	Office Fax #:
Address:	
Contact Person:	

Required by the New York State Department of Health Drug Utilization Review Board (NYSDOH DURB):

Prescriber Specialty: ☐ Hepatologist ☐ Gastroenterologist ☐ Transplant ☐ Infectious Disease

HCV Clinical Experience:

- ☐ Management of ≥ 20 patients with HCV infection within the last 12 months; and treatment for HCV in ≥ 10 patients within the last 12 months; and obtained ≥ HCV-related CME credits in the last 12 months
- ☐ Management & treatment of HCV infection in partnership with an experienced HCV provider who meets the above criteria (include collaborating provider's information below):
  Name: _____Phone#_____

MEDICATION REQUESTED*

Formulary Hepatitis C agent:

Select	Genotype	Drug
☐	1 or 4	Zepatier® (elbasvir/grazoprevir)
☐	2, 3, 5, or 6	Epclusa® (velpatasvir/sofosbuvir)

*Clinical Rational required for non-preferred (non-formulary) regimen with documentation of contraindication to preferred agents.

If additional agents are needed for HCV therapy, check below:

☐ Ribavirin

Treatment Duration: ☐ 12 Weeks ☐ 16 Weeks

PATIENT TREATMENT & EDUCATION READINESS

Treatment Readiness: (documentation required)

- ☐ Patient demonstration of readiness, willingness, and ability to adhere to the regimen

Education Readiness: (documentation required)

- ☐ Patient understands reinfection of Hepatitis C is still possible after being cured of Hepatitis C
- ☐ Patient understands not to engage in risky and unhealthy behaviors which would lead to reinfection.

Amida Care resources are available to support member adherence and lifestyle modification. Please check below to request any additional type of support or services for member

- ☐ Additional support needed for member by Amida Care (Please specify type of support or education needed):

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MEDICAL DIAGNOSIS AND CLINICAL CRITERIA

Please provide labs/documentation for verification of questions 1, 2, 4, 7-10*

1. Hep C Genotype: _____

2. **If HCV Genotype 1A, please provide lab results of NS5A polymorphism testing** (***Check appropriate box.)***

☐Patient does not have HCV Genotype 1A

☐Patient DOES NOT present with any baseline NS5A polymorphisms

☐Patient DOES present with baseline NS5A polymorphisms at amino acid positions 28, 30, 31 or 93.

☐Neither (**Please provide *explanation* and additional documentation)**

3. Most recent Baseline HCV RNA Viral titer/Viral Load (within 3 months):

4. What is the patient's prior treatment status?

☐ Treatment Naïve ☐Prior Relapse ☐Prior Partial Responder ☐Null Responder ☐Reinfection

PRIOR HEP C TREATMENT	DURATION/YEAR	OUTCOME OF TREATMENT
	/	
	/	
	/	

7. **Please provide documentation of most recent lab values for CD4 and HIV viral load.*(Check appropriate box.)***

☐Patient on ARVs and recent viral load under 200 copies/mL with CD4 count above 200

☐Patient electing not to be on ARVs and CD4 above 500

☐Neither (**Please provide *explanation* and documentation)**

8. Are there any comments, diagnosis, symptoms, and/or any other information pertinent to this review?

☐YES ☐NO *If **YES**, please specify:*_____

9. Has the patient had a liver enzyme level test and either a liver biopsy, Fibroscan or Fibrosure diagnostic test that demonstrates liver fibrosis or cirrhosis? *Please provide documentation demonstrating liver enzyme levels and stage of liver fibrosis or cirrhosis.*

☐ YES ☐NO

11. Does the prescriber agree to submit HCV-RNA levels at 4 weeks, end of treatment and 3 months post treatment (12 week SVR)?

☐YES ☐NO *If **NO**, please explain:*_____

Prior to making a coverage determination we would like to speak to the requesting prescriber by telephone in order to collect some additional information that might help us as we try to manage this therapy in the most efficient way possible. Please call 646-757-7605, M-F, 9:00-4:30 PM. You may also provide us with your contact information and the best time to reach you in the space designated at the top of this document.

_____ _____

Prescriber or Authorized Signature Date