



PRIOR AUTHORIZATION REQUEST: Hepatitis C Treatment

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

MEMBER INFORMATION

Name:	Medicaid 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 \geq 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#: _____

FORMULARY PREFERRED OPTIONS

Select	Indication	Presence of Cirrhosis	Medication Requested	Duration
<input type="checkbox"/>	Genotype 1, 2, 3, 4, 5, or 6: Treatment Naïve	Without cirrhosis	glecaprevir/pibrentasvir (Mavyret®)	8 weeks
<input type="checkbox"/>	Genotype 1, 2, 3, 4, 5, or 6: Treatment Naïve	Without cirrhosis or compensated cirrhosis	velpatasvir/sofosbuvir (ag Epclusa*)	12 weeks
<input type="checkbox"/>	Genotype 1, 2, 3, 4, 5, or 6: Treatment Naïve	With decompensated cirrhosis	velpatasvir/sofosbuvir (ag Epclusa*) + Ribavirin	12 weeks
<input type="checkbox"/>	Genotype 1, 2, 4, 5, or 6: Treatment experienced with IFN + RBV +/- sofosbuvir	Without cirrhosis	glecaprevir/pibrentasvir (Mavyret®)	8 weeks
<input type="checkbox"/>	Genotype 1, 2, 3, 4, 5, or 6: Treatment experienced with IFN + RBV +/- sofosbuvir	Without cirrhosis	velpatasvir/sofosbuvir (ag Epclusa*)	12 weeks
<input type="checkbox"/>	Genotype 1, 2, 4, 5, or 6: Treatment experienced with IFN + RBV +/- sofosbuvir	With decompensated cirrhosis	velpatasvir/sofosbuvir (ag Epclusa*)	12 weeks
<input type="checkbox"/>	Genotype 3: Treatment experienced with IFN + RBV +/- sofosbuvir	With decompensated cirrhosis	velpatasvir/sofosbuvir (ag Epclusa*) + Ribavirin	12 weeks
<input type="checkbox"/>	Genotype 1, 2, 3, 4, 5, or 6: Treatment experienced with IFN + RBV +/- sofosbuvir	With decompensated cirrhosis	velpatasvir/sofosbuvir (ag Epclusa*) + Ribavirin	12 weeks
<input type="checkbox"/>	Genotype 1: Treatment experienced with NS3/4A PI without prior NS5A inhibitor	Without cirrhosis	velpatasvir/sofosbuvir (ag Epclusa*)	12 weeks
<input type="checkbox"/>	Genotype 1: Treatment experienced with NS3/4A PI without prior NS5A inhibitor	Without cirrhosis or compensated cirrhosis	velpatasvir/sofosbuvir (ag Epclusa*) + Ribavirin	12 weeks
<input type="checkbox"/>	Genotype 1: Treatment experienced with NS5A inhibitor without prior NS3/4A PI	Without cirrhosis or with compensated cirrhosis	glecaprevir/pibrentasvir (Mavyret®)	16 weeks

**The authorized generic form of Epclusa (velpatasvir/sofosbuvir) is the preferred formulary agent*

- Clinical Rationale required for non-preferred (non-formulary) drug with documentation of contraindication to Epclusa or Mavyret:**



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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):

MEDICAL DIAGNOSIS AND CLINICAL CRITERIA

Please provide labs/documentation required for verification of questions

1. Hep C Genotype: _____
2. Most recent Baseline HCV RNA Viral titer/Viral Load (within 3 months): _____
3. 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
	/	
	/	
	/	

4. 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)

5. Please provide documentation of Hepatitis B virus (HBV) status:

- HBV negative Concurrent HBV is being treated Neither (Please provide explanation and documentation)

6. Has the patient had a liver enzyme level test and either a liver biopsy, Fibroscan or Fibrosure diagnostic test?

Please provide documentation demonstrating liver enzyme levels and stage of liver fibrosis or cirrhosis.

- YES NO If cirrhosis is present please check: Child Pugh Child Pugh B Child Pugh C

7. 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: _____

Please call 646-757-7615 or email dgreenidge@amidacareny.org M-F, 9:00-4:30 PM with questions or additional info. You may also provide us with your contact information and the best time to reach you in the space at the top of this document.

Prescriber or Authorized Signature

Date