



PRIOR AUTHORIZATION: Hepatitis C Retreatment

(As of 12/04/2020, Treatment-Naïve HCV Members **DO NOT** require
Prior Authorization for Mavyret or authorized generic of Epclusa)

Fax form and HCV labs to 1-646-786-0997 OR Email pharmacyfax@amidacareny.org

MEMBER INFORMATION

Name:	Medicaid ID #:
Phone # (Required):	Address:

PRESCRIBER INFORMATION

Name:	NPI:
Office Phone # (Required):	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 Other _____

FORMULARY PREFERRED OPTIONS

Select	Indication	Presence of Cirrhosis	Medication Requested	Duration
<input type="checkbox"/>	Genotype 1, 2, 3, 4, 5, or 6: Retreatment	Without cirrhosis	glecaprevir/pibrentasvir (Mavyret®)	8 weeks
<input type="checkbox"/>	Genotype 1, 2, 3, 4, 5, or 6: Retreatment	Without cirrhosis or compensated cirrhosis	velpatasvir/sofosbuvir (ag Epclusa*)	12 weeks
<input type="checkbox"/>	Genotype 1, 2, 3, 4, 5, or 6: Retreatment	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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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 * Toxicities/Side Effects
 - Reinfection; Prior HCV Genotype: _____ (only if reinfection is checked)
 - Other/Additional Information: _____

***Prior Relapse:** If HCV RNA decreases and remains below the limit of detection (<50 IU/mL) during treatment but becomes detectable after cessation of treatment ***Partial Responder:** Demonstrate a > 2-log decline in HCV RNA at treatment week 12 (EVR) but fail to achieve an undetectable level at week 24. ***Null Responder:** <2-log₁₀ reduction in HCV RNA level at week 12

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 A 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)? HCV labs can be faxed to 1-646-786-0997 OR emailed to jalim@amidacareny.org or cmilan@amidacareny.org with subject line "4 Weeks SVR" or "End of Treatment SVR" or "12 week Post Treatment SVR" without quotations

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

Please call 646-757-7979 or email pharmacyfax@amidacareny.org M-F, 9:00 AM - 6:00 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