MedStar Medicare Choice
Pharmacy Services
Phone: 855-266-0712
Fax: 855-862-6517

HEPATITIS C PRODUCTS
Prior Authorization Form

□ Standard Request (72 hours) □ Expedited Request (24 hours)	If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:
Quantity Dispensed:	Day Supply:	□ Generic □ Brand Necessary

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Clinical Information

Diagnosis:	Date Diagnosed:

Does the member have a diagnosis of chronic Hepatitis C? □Yes □No

Please indicate genotype:_____

Please submit chart documentation of the laboratory test which confirmed the genotype.

Does the member have cirrhosis? □Yes □No

**If yes, please submit chart doc. of the biopsy, ultrasound, CT scan, or MRI that confirmed the presence of cirrhosis.

Is the patient interferon ineligible? □Yes □No

**If yes, please provide chart documentation of clinical rationale and 1 of the following: decompensated cirrhosis with Child-Pugh greater than 6, platelet count <90,000/mm^3, ANC <1500/mm^3, SrCr >1.5xULN, CD4 count <100/mm^3 with HIV co-infection, hemoglobin <10g/dL, retinopathy, autoimmune disease, severe uncontrolled psych disease classified by chart documentation of evaluation by behavioral health specialist, history of preexisting unstable heart disease, side effects to prior interferon treatment leading to discontinuation.

For Sovaldi requests for genotype 1, has patient previously tried Harvoni? □Yes □No

***If no, please provide clinical rationale for not being able to use Harvoni

What regimen is being prescribed for the patient and what is the duration of therapy being requested?

_____

_____

Has the member been previously treated for chronic hepatitis C? ☐ Yes ☐ No

If yes, please indicate response to prior therapy: (please provide dates of therapy)

☐ Relapser Please provide dates of therapy:_____

☐ Partial Responder Please provide dates of therapy:_____

☐ Null Responder Please provide dates of therapy:_____

Quantitative Hepatitis C Virus Titers (HCV RNA)		
Treatment Timeline	**Date of Test**	**HCV RNA Result**
☐ Baseline:		
☐ Treatment Week 4		
☐ Treatment Week 8		
☐ Treatment Week 12		
☐ Treatment Week 24		

Please attach chart documentation of HCV RNA results showing date, reference range, and assay.

Note: assay used to determine HCV RNA levels must have a lower limit of HCV RNA quantification of ≤25 IU/mL and a limit of HCV RNA detection of approximately 10-15 IU/mL

Please provide any additional information which should be considered in the space below: