UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Hepatitis C Direct-acting Antivirals

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Demographics Required:

*Member Phone Number:
*Residential Status *(group home, treatment program, address of residence, etc.):*

Criteria for Approval:

Does the patient have a diagnosis of chronic hepatitis C infection genotype 1,2,3,4,5, or 6 confirmed by lab documentation and quantitative baseline HCV-RNA? ☐ Yes ☐ No

**** YES, to the above, proceed to part 1 ** NO, use the Medication Coverage Exception Prior Authorization**

<u>Part 1</u>: *All questions below MUST be answered with documentation and chart notes provided as appropriate*:

a. Has the patient been previously treated for HCV? ☐ Yes ☐ No
b. Has the patient previously had a liver or kidney transplant? ☐ Yes ☐ No
c. Does the patient have compensated cirrhosis (Child Pugh class A)? ☐ Yes ☐ No
d. Does the patient have decompensated cirrhosis (Child Pugh class B or C)? ☐ Yes ☐ No
e. Is the patient co-infected with HIV or Hepatitis B? ☐ Yes ☐ No
f. Does the patient have known or suspected hepatocellular carcinoma? ☐ Yes ☐ No
g. Is the patient pregnant? (current guidelines do not recommend treatment) ☐ Yes ☐ No
h. Will treatment be with an agent other than sofosbuvir/velpatasvir or Mavyret? ☐ Yes ☐ No

**** YES, to ANY above, proceed to part 2. ** NO, to ALL above, proceed to part 3.**

<u>Part 2:</u>

a. If the patient has been previously treated for HCV:
   i. Please specify the previous treatment and length: _____
   ii. The patient had an interruption in treatment due to medication nonadherence, please specify the nonadherence issue(s): _____
   Chart notes page number: _____
   iii. The previous issue(s) related to medication nonadherence has been resolved and the patient has been counseled on the importance of adherence to HCV treatment ☐ Yes ☐ No
b. The prescriber is or has consulted with:
   ☐ Infectious disease specialist ☐ Hepatologist ☐ Gastroenterologist

c. Which HCV genotype is being treated? Submit laboratory confirmation of the HCV genotype with this request.
☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

d. Patient's HCV RNA level: _____

e. Requested duration of therapy? ☐ 8 week ☐ 12 weeks ☐ 12 weeks with ribavirin
☐ 16 weeks ☐ 24 weeks ☐ 24 weeks with ribavirin ☐ Other weeks requested: _____

f. Prescriber must demonstrate medical necessity for non-preferred product.
Details: _____Chart Note Page #: _____

Part 3:

a. Requested duration of therapy?
☐ 8 weeks with Mavyret ☐ 12 weeks with generic sofosbuvir/velpatasvir

Authorization: Single course of treatment

Note: ❖ Patient should be evaluated and/or counseled on clinically significant drug to drug interactions.

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____
Prescriber's Signature Date