

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

Direct-acting ant-viral treatments for
Hepatitis C

Patient name: _____ Medicaid ID #: _____
Prescriber Name: _____ Prescriber NPI#: _____
Prescriber Phone#: _____ Extension/Option: _____
Prescriber's office contact person: _____ Prescriber Fax#: _____
Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____
Requested Medication: _____ Strength: _____ Frequency: _____

All information to be legible, complete and correct or form will be returned

FAX REQUIRED DOCUMENTATION AND PROGRESS NOTES TO 855-828-4992

CRITERIA:

- Diagnosis of Hepatitis C
- Patient must undergo Hepatitis C genotype testing and submit a copy of the testing results. The requested agent must be FDA-approved to treat the patient's genotype. FDA-approved genotype indications:
 - Daklinza: 1, 3
 - Epclusa: 1, 2, 3, 4, 5, 6
 - Harvoni: 1, 4, 5, 6
 - Olysio: 1, excluding 1a
 - Sovaldi: 1, 2, 3, 4
 - Technivie: 4
 - Viekira & Viekira XR: 1a, 1b
 - Zepatier: 1a, 1b, 4
- Prescriber is, or has consulted with, an infectious disease physician, hepatologist, gastroenterologist or a physician assistant or nurse practitioner who practices with an infectious disease physician, hepatologist, or gastroenterologist.
- Patient shows evidence of at least one of the following:
 - fibrosis without hepatic failure
 - or
 - extrahepatic manifestations

Initial Authorization Period: 12 weeks

Reauthorization: Note that, in many cases, the initial authorization will suffice for a full treatment course. If continued treatment is desired, please re-submit all of the above and a letter of medical necessity.

08/08/2016

<http://health.utah.gov/medicaid/pharmacy>