# Hepatitis C Direct-acting Antivirals

| Member and Medication Information (required) | |
|---|---|
| Member ID: | Member Name: |
| DOB: | Weight: |
| Medication Name/ Strength: | Dose: |
| Directions for use: | |

| Provider Information (required) | | |
|---|---|---|
| Name: | NPI: | Specialty: |
| Contact Person: | Office Phone: | Office Fax: |

**FAX FORM AND RELEVANT DOCUMENTATION INCLUDING: LABORATORY RESULTS, CHART NOTES and/or UPDATED PROVIDER LETTER TO 855-828-4992**

**Criteria for Approval:**

**Part 1: 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
   If yes, please specify the previous treatment and length: _____
b. Has the patient previously had a liver or kidney transplant? ☐ Yes ☐ No
c. Does the patient have severe renal impairment or end-stage renal disease? ☐ Yes ☐ No
d. Does the patient have compensated cirrhosis (Child Pugh class A)? ☐ Yes ☐ No
e. Does the patient have decompensated cirrhosis (Child Pugh class B or C)? ☐ Yes ☐ No
f. Is the patient co-infected with HIV or Hepatitis B? ☐ Yes ☐ No
g. Does patient have known or suspected hepatocellular carcinoma? ☐ Yes ☐ No
h. Is the patient pregnant? (current guidelines do not recommend treatment) ☐ Yes ☐ No
i. 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.**

**Part 2:**

1) The prescriber is or has consulted with: ☐ Infectious disease specialist ☐ Hepatologist ☐ Gastroenterologist
2) Which HCV genotype is being treated? Submit laboratory confirmation of the HCV genotype with this request.
   ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
3) Patient's HCV RNA level: _____
4) Requested duration of therapy? ☐ 8 weeks ☐ 12 weeks ☐ 12 weeks with ribavirin
   ☐ 16 weeks ☐ 24 weeks ☐ 24 weeks with ribavirin ☐ Other Number of weeks requested: _____
5) Prescriber must demonstrate medical necessity for non-preferred product.
   Details: _____ Chart Note Page #: _____

**Part 3:**

1) Requested duration of therapy? ☐ 8 weeks with Mavyret ☐ 12 weeks with 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