

## HEPATITIS C AGENTS PRIOR AUTHORIZATION FORM

The prior authorization guidelines for Hepatitis C Agents and Quantity Limits/Daily Dose Limits can be found on the Department's Pharmacy Services website, accessible at <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>.

PRIOR AUTHORIZATION REQUEST INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request: _____	Prescriber name: _____		
<input type="checkbox"/> Renewal request	PA#: _____				
Name/phone # of office contact: _____			Specialty: _____		
LTC facility contact/phone: _____			State license #: _____	NPI: _____	
RECIPIENT INFORMATION			Street address: _____		
Recipient Name: _____			Suite #: _____	City/state/zip: _____	
Recipient ID#: _____	DOB: _____	Phone: _____	Fax: _____		

### CLINICAL INFORMATION

<b>Medication(s) requested:</b> <i>(check all that apply to request – all agents listed require prior auth.)</i>	<input type="checkbox"/> Copegus tab (NP)	<input type="checkbox"/> Olysio (NP)	<input type="checkbox"/> Ribapak (NP)	<input type="checkbox"/> Sovaldi* <sup>PA</sup>	<input type="checkbox"/> Zepatier* <sup>PA</sup>
	<input type="checkbox"/> Daklinza* <sup>PA</sup>	<input type="checkbox"/> Pegasys* <sup>PA</sup>	<input type="checkbox"/> Ribasphere tablet (NP)	<input type="checkbox"/> Technivie* <sup>PA</sup>	<input type="checkbox"/> _____
	<input type="checkbox"/> Harvoni* <sup>PA</sup>	<input type="checkbox"/> Peg-Intron* <sup>PA</sup>	<input type="checkbox"/> ribavirin dose pack (NP)	<input type="checkbox"/> Viekira Pak* <sup>PA</sup>	<input type="checkbox"/> _____
	<input type="checkbox"/> Moderiba tab (NP)	<input type="checkbox"/> Rebetol (NP)	<input type="checkbox"/> ribavirin tablet (NP)		
<i>(NP) denotes agent is non-preferred; *<sup>PA</sup> denotes an agent is preferred and requires a clinical prior authorization</i>					
Drug #1 name/strength/dosage form: _____	Directions: _____		Qty: _____	Refills: _____	
Drug #2: _____	Directions: _____		Qty: _____	Refills: _____	
*Hepatitis C agents are part of the Specialty Pharmacy Drug Program. Which specialty pharmacy will be used?				<input type="checkbox"/> Diplomat Specialty Pharmacy <input type="checkbox"/> Walgreen's Specialty Pharmacy	

#### SECTION A: ALL INITIAL REQUESTS:

1. What is the Recipient's genotype? <input type="checkbox"/> 1a <input type="checkbox"/> 1b <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	Date of testing: _____	<i>Submit documentation of test results.</i>
2. What is the Recipient's baseline viral load? _____	Date of testing: _____	<i>Submit documentation of results within past 3 months.</i>
3. What is the Recipient's Metavir fibrosis score? <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	Date of testing: _____	<i>Submit documentation of test results.</i>
4. Does the Recipient have results of a recent serum creatinine (SCr) level?	<input type="checkbox"/> Yes – <i>submit documentation of lab results.</i> <input type="checkbox"/> No	
5. Is the Recipient taking any medications that interact with the medication(s) being requested?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit Recipient's complete medication list.</i>	
6. Was the Recipient previously treated for hepatitis C?	<input type="checkbox"/> Yes – <i>submit documentation of previous treatment regimen, treatment dates, lab work, and outcome.</i> <input type="checkbox"/> No	
7. Does the Recipient have a history of substance abuse or dependency?	<input type="checkbox"/> Yes – <i>submit documentation of prescriber counseling regarding the risks of alcohol or IV drug abuse and an offer of a referral for substance use disorder treatment.</i> <input type="checkbox"/> No	
8. Does the Recipient have HIV or hepatitis B (HBV)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation of positive or negative HIV and hepatitis B test results from within the past 3 months AND documentation of hepatitis B vaccination or, if positive for HBV, documentation of treatment</i>
9. Does the Recipient have a history of a liver transplant or severe extrahepatic manifestations of hepatitis C?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>	
10. Does the Recipient have documented commitment to adherence with the planned course of treatment and mutual monitoring by the prescriber and the Department?	<input type="checkbox"/> Yes – <i>submit medical record documentation.</i> <input type="checkbox"/> No	
11. Will the Recipient be taking ribavirin?	<input type="checkbox"/> Yes – <i>submit documentation of CBC with differential (within past 3 months) and, if female, a recent negative pregnancy test and contraceptive measures that will be used.</i> <input type="checkbox"/> No	

#### SECTION B: ALL NON-PREFERRED REQUESTS (NON-PREFERRED DIRECT ACTING ANTIVIRALS (DAAs), RIBAVIRIN PRODUCTS, AND INTERFERON PRODUCTS)

1. Has the Recipient tried and failed, or have a contraindication or intolerance to, the preferred agents listed below in the same drug class/type as the requested non-preferred agent (ex. DAAs, ribavirins, or interferons)?	<input type="checkbox"/> Yes – <i>submit documentation of contraindication, intolerance, or drug regimen tried and failed.</i> <input type="checkbox"/> No
<b>Preferred direct acting antivirals</b> <input type="checkbox"/> Daklinza* <sup>PA</sup> <input type="checkbox"/> Technivie* <sup>PA</sup> <input type="checkbox"/> Harvoni* <sup>PA</sup> <input type="checkbox"/> Viekira Pak* <sup>PA</sup> <input type="checkbox"/> Sovaldi* <sup>PA</sup> <input type="checkbox"/> Zepatier* <sup>PA</sup>	
<b>Preferred ribavirins</b> <input type="checkbox"/> Ribavirin capsule <input type="checkbox"/> Pegasys* <sup>PA</sup> <input type="checkbox"/> Ribasphere 200mg capsule <input type="checkbox"/> Peg-Intron* <sup>PA</sup>	
<b>Preferred interferons</b> <input type="checkbox"/> Ribavirin capsule <input type="checkbox"/> Pegasys* <sup>PA</sup> <input type="checkbox"/> Ribasphere 200mg capsule <input type="checkbox"/> Peg-Intron* <sup>PA</sup>	

### PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____	Date: _____
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