



Prior Authorization (PA) Form
HEPATITIS C ANTIVIRALS: NON-PREFERRED

If the following information is not complete, correct, or legible, the PA process can be delayed.

Please use one form per member.

If your request is for Mavyret™ or sofosbuvir/velpatasvir, please use **Hepatitis C Antivirals: Preferred** PA Form.

MEMBER INFORMATION

Last Name:

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First Name:

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Medicaid ID Number:

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Date of Birth:

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Gender: Male Female

Member Age: _____

PRESCRIBER INFORMATION

Last Name:

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First Name:

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NPI Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Phone Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Fax Number:

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Prescriber Specialty: Hepatitis C medication must be prescribed by one of the speciality physicians below or be in consultation with: Below Indicate the prescriber’s speciality or in consultation with:

- Gastroenterologist Hepatologist Transplant Specialist Infectious Disease
 Other: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

<https://mediproviders.anthem.com/va>

Hepatitis C Antivirals: Non-Preferred

Member's Last Name:

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Member's First Name:

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DIAGNOSIS

- Chronic Hepatitis C Compensated cirrhosis Hepatocellular carcinoma
 Decompensated cirrhosis (Child-Pugh score class B or C) Status post-liver transplant

HCV Genotype:

- 1a with polymorphism (*submit test results*) 1a without polymorphism (*submit test results*)
 1b 2 3 4 5 6

Choose One: Treatment initiation Continuation of therapy, current week: _____

Member Readiness Review

- Member compliance to treatment regimen.
- Member does not have Hepatitis B.
- Member is not pregnant, breastfeeding or planning to breastfeed
- Member is not taking atazanavir or rifampin.
- Member does not have severe kidney problems or is not on dialysis.
- Member does not have HIV.
- Member does not have severe liver cirrhosis or a Child-Pugh score class B or C.

Possible side effects include: nausea; tiredness; yellowing of skin or white part of eyes; bleeding or bruising more easily than normal; confusion; dark, black, or bloody stool; loss of appetite; diarrhea; dark or brown (tea-colored) urine; swelling or pain on the upper right side of stomach area (abdomen); sleepiness; vomiting of blood; or lightheadedness.

OTHER CO-MORBID CONDITION(S)

1. Decompensated cirrhosis (Child-Pugh score greater than 6 [class B or C])?
 Yes No
2. Hx severe renal impairment (eGFR <30 mL/min/1.73m²) or end stage renal disease requiring hemodialysis?
 Yes No
3. If Yes to any, provide details: _____

(Form continued on next page.)

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Member's Last Name:

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Member's First Name:

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PREVIOUS HEPATITIS C TREATMENTS

Treatment naïve

Treatment experienced with (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Daklinza™ (daclatasvir) | <input type="checkbox"/> Epclusa® (sofosbuvir/velpatasvir) |
| <input type="checkbox"/> Harvoni® (ledipasvir-sofosbuvir) | <input type="checkbox"/> Incivek® (telaprevir) |
| <input type="checkbox"/> Interferon | <input type="checkbox"/> ledipasvir-sofosbuvir |
| <input type="checkbox"/> Olysio™ (simeprevir) | <input type="checkbox"/> peginterferon |
| <input type="checkbox"/> ribavirin | <input type="checkbox"/> sofosbuvir/velpatasvir |
| <input type="checkbox"/> Sovaldi® (sofosbuvir) | <input type="checkbox"/> Technivie® (ombitasvir/paritaprevir/ritonavir) |
| <input type="checkbox"/> Viekira Pak™ (ombitasvir/paritaprevir/ritonavir) with dasabuvir | |
| <input type="checkbox"/> Viekira XR™ (ombitasvir/paritaprevir/ritonavir; dasabuvir) | |
| <input type="checkbox"/> Zepatier™ (elbasvir and grazoprevir) | |

Document dates received: _____

Prescriber Signature (Required)

Date

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.

Submission of documentation does NOT guarantee coverage.

The completed form may be **FAXED TO 1-844-512-7020**.