MC RX PBM SERVICES/JAI MEDICAL SYSTEMS MANAGED CARE ORGANIZATION, INC.
Call Clinical Services Department at 1-800-555-8513 or Fax 1-800-583-6010 or 1-866-999-7736. MC Rx will respond by fax or phone within 24 hours of receipt of this request.

HEPATITIS C THERAPY PRIOR AUTHORIZATION FORM

Incomplete forms will be returned

Please attach copies of the patient's medical history summary, lab and genetic test reports, and signed treatment agreement form(optional) and treatment plan.
****Please review our clinical criteria before submitting this form. ****

Patient Information

Recipient: _____ MA#: _____

Date of Birth: _____/_____/_____ Phone #: (_____) _____ - _____ Body Weight: _____ kg

Treatment

If requesting a non-preferred treatment, please specify why preferred treatments are not appropriate

☐ Mavyret (Preferred for all genotypes): Take _____daily for _____ weeks

☐ Sofosbuvir-Velpatasvir (Preferred for all genotypes): Take _____daily for _____ weeks

☐ Vosevi (Retreatment only): Take _____daily for _____ weeks

☐ Ledipasvir-Sofosbuvir (Preferred for genotype 1,4,5,6): Take _____daily for _____ weeks

☐ _____: Take _____daily for _____ weeks

☐ _____: Take _____daily for _____ weeks

Adherence with prescribed therapy is a condition for payment of therapy for up to the allowed timeframe for each HCV genotype.

Has a treatment plan been developed and discussed with patient? ☐ No ☐ Yes

Diagnosis

☐ Acute Hep C ☐ Chronic Hep C (Hep C present for ≥ 6 months as established by (please select one)

□ Lab testing such as an HCV antibody or HCV RNA test completed 6 months apart

□ HCV diagnosis documented in prescribers note from the past office visit(s)

□ Exposure risk history documented in prescribers notes from the past office visit(s)

☐ Liver transplant recipient: Genotype of pre-transplant liver: _____

Genotype of post-transplant liver: _____

☐ Other:_____

What is the patient's HCV genotype and subtype? _____

Has a liver biopsy been performed? ☐ No ☐ Yes; Test date: _____/_____/_____

Has a fibrosis test been performed: ☐ No ☐ Yes; Test used: _____; Test date: _____/_____/_____

Metavir Grade: _____; Metavir Stage: _____

Child Pugh Score (required for treatment of some patients with cirrhosis): _____

What best describes this patient's liver disease? (Check all that apply):

☐ No cirrhosis ☐ Compensated cirrhosis ☐ Decompensated liver disease

****Please provide a copy of the results of the biopsy, genotype, and any other fibrosis tests for this patient. ****

Hepatitis C Treatment History

Has this patient been treated for Hepatitis C in the past: ☐ Treatment Naive ☐ Treatment Experienced

If Treatment Experienced, what was the outcome of the previous treatments:

☐ Relapsed ☐ Partial Responder ☐ Non-Responder ☐ Toxicities ☐ Reinfection

Genotype pre-DAA therapy: _____ Genotype post-DAA therapy: _____

Please indicate what prior regimen(s) the patient has been treated with:

HCV regimen	Treatment duration/ dates	Treatment Outcome
		☐ Relapsed ☐ Partial Responder ☐ Non-Responder ☐ Toxicities ☐ Reinfection ☐ Other: _____
		☐ Relapsed ☐ Partial Responder ☐ Non-Responder ☐ Toxicities ☐ Reinfection ☐ Other: _____

Laboratory Results

Recent baseline HCV RNA level (up to and including **180* days prior**): _____ Date:____/____/_____

***unless the patient is cirrhotic then the baseline lab values must be within 90 days of prior authorization request**

For cirrhotic patients please attach recent (within 90 days of PA request) total bilirubin, albumin, and INR

If a regimen is prescribed containing ribavirin, please attach recent hemoglobin, hematocrit, and platelet count.

Medical History (Recent = 6 months prior to request for noncirrhotic or 3 months for cirrhotic patients)

Is the patient co-infected with HIV? ☐ No ☐ Yes; If yes, state the patient's recent HIV viral load? _____
Date drawn: _____

Is the patient co-infected with HBV? ☐ No ☐ Yes; If yes, state the patient's recent HBV viral load? _____
Date drawn: _____

Is the patient co-infected with other viral infection: _____

Has patient had a solid organ transplant? ☐ No ☐ Yes; If yes, specify what type of transplant: _____
Date of transplant: _____/_____/_____

Adherence Assistance

If the member needs assistance in order to successfully adhere to treatment, please explain what assistance is needed. If there are special instructions for contacting the member, please include. All members will be offered Case Management for Hepatitis C treatment. If member contact needs to go through provider office or pharmacy, please include.
In order to determine lab and refill timeframes, please inform the Case Manager or MCO of actual treatment start date once member starts taking medication and please inform Case Manager or MCO if member discontinues treatment.

If the patient's Medicaid eligibility changes during therapy and the patient is no longer eligible for Medicaid prescription drug assistance, is the physician prepared to enroll the patient in other patient assistant drug programs to complete therapy? ☐ Yes ☐ No

Contact Person at your office: (name):_____Telephone #:_____

I certify that the benefits of the treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

_____

Prescriber's signature Prescriber's Name Date

Telephone# (_____) – _____- _____ Fax# (_____) - _____ - _____

Practice Specialty: _____

Address: _____