

# 2019 General Hepatitis C Treatment Coverage Determination Request

Page 1 of 3

(You must complete all 3 pages.)

Fax completed form to: 1-800-408-2386

For urgent requests, please call: 1-800-414-2386

Patient information		Prescriber information	
Patient name		Today's date	Physician specialty
Patient insurance ID number		Physician name	NPI/DEA number
Patient address, city, state, ZIP		Physician address, city, state, ZIP	
Patient home telephone number		M.D. office telephone number	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient date of birth	M.D. office fax number	

Requested regimen: (check all that apply)	Please indicate if this is a new start or continuation of therapy and specify the requested duration of therapy. <b>If continuation of therapy please indicate start date.</b>				
Medication	Dose/Frequency	New start	Continuation	Initial start date	Duration of therapy
<input type="checkbox"/> Daklinza® (daclatasvir)		<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Epclusa® (sofosbuvir and velpatasvir)		<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Harvoni® (ledipasvir-sofosbuvir)		<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Intron-A® (interferon alfa-2b)		<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Mavyret® (glecaprevir/pibrentasvir)		<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Olysio® (simeprevir)		<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Pegasys® (pegylated interferon alfa-2a)		<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Peg-Intron® (pegylated interferon alfa-2a)		<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> ribavirin *prior authorization(PA) not required		<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Sovaldi® (sofosbuvir)		<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Technivie® (ombitasvir/paritaprevir/ritonavir)		<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Viekira Pak® (ombitasvir/paritaprevir/ritonavir/dasabuvir)		<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Vosevi® (sofosbuvir/velpatasvir/voxilaprevir)		<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Zepatier® (elbasvir/grazoprevir)		<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Other (Please specify) _____		<input type="checkbox"/>	<input type="checkbox"/>		

**Diagnosis and medical information**

**Diagnosis (If treatment experienced, list all components of previous treatment regimens and describe outcome)**  
 Chronic hepatitis C treatment naive     Chronic Hepatitis C treatment experienced     Other diagnosis/(ICD10): \_\_\_\_\_

**What is the patient's HCV genotype?**  
 1a     1b     2     3     4     5     6     Other (specify): \_\_\_\_\_

**Medical history (Please check all boxes that apply and include office notes)**

<input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis B coinfection	<input type="checkbox"/> Yes <input type="checkbox"/> No HIV coinfection	<input type="checkbox"/> Yes <input type="checkbox"/> No End stage renal disease
<input type="checkbox"/> Yes <input type="checkbox"/> No Hepatocellular carcinoma	<input type="checkbox"/> Yes <input type="checkbox"/> No Received a liver transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No Received a kidney transplant

**Which of the following tests were used to determine liver stage? (Please check all boxes that apply and include medical records as supporting documentation)**  
 Liver biopsy     Metavir     Fibroscan     APRI     ARFI     SWEI     Other (specify): \_\_\_\_\_

**Which of the following best describe patient's liver disease, based on liver staging tests (liver biopsy, Metavir, Fibroscan, etc.), radiological imaging, physiologic or clinical findings? (Please check box that best describe patient's liver disease and include medical records as supporting documentation)**  
 No cirrhosis     Compensated cirrhosis     Decompensated cirrhosis

(continued on page 2)

**Fax Confidentiality Notice:** The information contained in this transmission is confidential, proprietary or privileged and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act (HIPAA). The message is intended for the sole use of the individual or entity to whom it is addressed. If you are not the intended recipient, you are notified that any use, distribution or copying of the attached material is strictly prohibited and may subject you to criminal or civil penalties. **If you received this transmission in error, please notify us immediately by telephone at 1-800-414-2386.**

**Diagnosis and medical information (continued)**

Was testing for the presence of virus with NS5A resistance-associated polymorphisms performed?  Yes  No

If testing was done, does the patient have NS5A resistance-associated polymorphism at amino acid positions 28, 30, 31, or 93?  
 Yes  No

If testing was not done, provide a reason for why testing was not done:

---

Has patient been screened for the presence of virus with the NS3 Q80K polymorphism at baseline?  Yes  No

If screening was done, does patient have Q80K polymorphism?  Yes  No

If screening was not done, provide a reason for why screening was not done:

---

**Please check all boxes that apply:**

1.  All covered Part D drugs on any tier of the plan's formulary would not be as effective for the enrollee as the requested formulary drug and/or would likely have adverse effects for the enrollee.

2.  Yes  No Is the prescriber a gastroenterologist, hepatologist, infectious disease specialist OR a consult was obtained from one of these specialists? If NO, complete section below:

**Please complete this section below only if your patient does not meet the standard requirements listed above.**

Please explain why your patient should be considered for exception although not meeting the plan's suggested PA criteria. Statement should include specifically which requirement is not met and why patient should be exempt from meeting this requirement. (Please note any information that is incomplete or illegible will delay the review process.)

---

**3. If patient is treatment experienced, please complete this section:**

Yes  No Has patient been treated with ribavirin and/or peginterferon alfa? If yes, list all components of previously treated regimen below and check the box that best describe treatment outcome.

HCV regimen	Treatment duration/dates	Treatment outcome
		<input type="checkbox"/> Relapsed <input type="checkbox"/> Partial responder <input type="checkbox"/> Non-responder <input type="checkbox"/> Toxicities <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Relapsed <input type="checkbox"/> Partial responder <input type="checkbox"/> Non-responder <input type="checkbox"/> Toxicities <input type="checkbox"/> Other: _____

Yes  No Has patient been treated with regimens containing Eplclusa®, Incivek®, Harvoni®, Victrelis®, Olysio®, Sovaldi®, Zepatier®, Daklinza®, Technivie®, Mavyret®, Vosevi® or Viekira® Pak? If yes, list all components of previously treated regimen below and check the box that best describe treatment outcome.

HCV regimen	Treatment duration/dates	Treatment outcome
		<input type="checkbox"/> Relapsed <input type="checkbox"/> Partial responder <input type="checkbox"/> Non-responder <input type="checkbox"/> Toxicities <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Relapsed <input type="checkbox"/> Partial responder <input type="checkbox"/> Non-responder <input type="checkbox"/> Toxicities <input type="checkbox"/> Other: _____

**4. Will patient be taking ribavirin with the requested regimen?**

Yes (ribavirin is covered without PA)  No, patient is intolerant/ineligible for ribavirin

(continued on page 3)

Please check all boxes that apply (*continued*):

5.  **Other supporting information**

\*NOTE: All exception requests require prescriber supporting statements. Additionally, requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Please attach supporting information, as necessary, for your request.

---



---



---



---



---

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733. By signing this form, I represent that I have obtained patient consent as required under applicable state and federal law, including but not limited to the Health Information Portability and Accountability Act (HIPAA) and state re-disclosure laws related to HIV/AIDS.

<b>Prescriber signature</b>	<b>Date</b>
-----------------------------	-------------