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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 ☐ Male ☐ 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. **If continuation of therapy please indicate start date.**

Medication	**Dose/Frequency**	**New start**	**Continuation**	**Initial start date**	**Duration of therapy**
☐ Daklinza® (daclatasvir)		☐	☐		
☐ Epclusa® (sofosbuvir and velpatasvir)		☐	☐		
☐ Harvoni® (ledipasvir-sofosbuvir)		☐	☐		
☐ Intron-A® (interferon alfa-2b)		☐	☐		
☐ Mavyret® (glecaprevir/pibrentasvir)		☐	☐		
☐ Olysio® (simeprevir)		☐	☐		
☐ Pegasys® (pegylated interferon alfa-2a)		☐	☐		
☐ Peg-Intron® (pegylated interferon alfa-2a)		☐	☐		
☐ ribavirin *prior authorization(PA) not required		☐	☐		
☐ Sovaldi® (sofosbuvir)		☐	☐		
☐ Technivie® (ombitasvir/paritaprevir/ritonavir)		☐	☐		
☐ Viekira Pak® (ombitasvir/paritaprevir/ritonavir/ dasabuvir)		☐	☐		
☐ Vosevi® (sofosbuvir/velpatasvir/voxilaprevir)		☐	☐		
☐ Zepatier® (elbasvir/grazoprevir)		☐	☐		
☐ Other (Please specify) _____		☐	☐		

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)***

☐ **Yes** ☐ **No** Hepatitis B coinfection ☐ **Yes** ☐ **No** HIV coinfection ☐ **Yes** ☐ **No** End stage renal disease

☐ **Yes** ☐ **No** Hepatocellular carcinoma ☐ **Yes** ☐ **No** Received a liver transplant ☐ **Yes** ☐ **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)

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
		☐ Relapsed ☐ Partial responder ☐ Non-responder ☐ Toxicities ☐ Other:
		☐ Relapsed ☐ Partial responder ☐ Non-responder ☐ Toxicities ☐ Other:

☐ **Yes** ☐ **No** Has patient been treated with regimens containing Epclusa®, 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
		☐ Relapsed ☐ Partial responder ☐ Non-responder ☐ Toxicities ☐ Other:
		☐ Relapsed ☐ Partial responder ☐ Non-responder ☐ Toxicities ☐ 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.

Prescriber signature	**Date**