COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

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E-MAIL: DPWPharmacyServices@pa.gov

HEPATITIS C AGENTS – INITIAL REQUEST

PRIOR AUTHORIZATION FORM

To review the prior authorization guidelines for Hepatitis C Agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter- Hepatitis C Agents at http://www.dpw.state.pa.us/publications/bulletinsearch/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New ☐ Additional Information

For Additional Information: Coordinator Name:_____ PA#:_____

Number of Pages in this Request:_____ Office Contact Name:_____ & Phone:(_____)_____

RECIPIENT INFORMATION

Name:_____ Recipient ID#:_____ Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Name:_____ Specialty:_____

NPI#:_____ **OR** MA Provider ID#:_____ State License#:_____

Prescriber Address: _____ Suite #:_____

City/State/Zip:_____ Phone:(_____)_____ Fax:(_____)_____

MEDICAL INFORMATION

1. Drug(s) Requested: Preferred Drugs: ☐ Incivek ☐ Olysio ☐ Pegasys ☐ Peg-Intron ☐ Sovaldi ☐ Victrelis

Non-Preferred Drugs: ☐ Copegus ☐ Infergen ☐ Rebetol ☐ Ribasphere 400 mg & 600 mg ☐ Ribapak

2. Strength: _____ Dosage Form:_____ Directions:_____ Quantity: _____ Refills: ____
Strength: _____ Dosage Form:_____ Directions:_____ Quantity: _____ Refills: ____
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3. Diagnosis:_____ Diagnosis Code:_____ *(Required)*

4. Hepatitis C Agents are part of the Specialty Pharmacy Drug Program – which Specialty pharmacy will be used?
☐ Accredo Health Group ☐ Walgreen's Specialty Pharmacy

For All Initial Requests

1. What is the recipient's genotype? ☐ 1 ☐ 2 ☐ 3 ☐ 4 **Date of testing:_____** (*submit documentation)*

2. What is the recipient's baseline viral load*?_____ Date of testing: _____(*submit documentation)*

3. What is the recipient's current weight? _____kg / lb Date:_____(*submit documentation)*

4. What is the recipient's Metavir fibrosis score? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 **Date of testing:_____** (*submit documentation)*

5. Does the recipient have results of a recent serum creatinine (SCr) level? ☐ Yes (*submit documentation)* ☐ No

6. Has the recipient ever been previously treated for Hepatitis C? ☐ Yes *(submit documentation & outcome of treatment)* ☐ No

7. Does the recipient have any history of substance abuse/dependency?
☐ Yes *(submit documentation of current abstinence including UDS and any treatments)* ☐ No

8. If prescribed interferon, does the recipient have any significant psychiatric diagnoses?
☐ Yes *(submit documentation & clearance from psychiatrist)* ☐ No *(submit documentation of mental health evaluation by prescriber)*

9. Does the recipient have any of the following?
-Decompensated Cirrhosis ☐ Yes ☐ No
-Autoimmune Hepatitis ☐ Yes ☐ No *(submit documentation of negative ANA*)*
-HIV ☐ Yes *(submit documentation)* ☐ No *(submit documentation of negative HIV test**)*

10. Will the recipient be taking ribavirin?
☐ Yes *(submit documentation of CBC with differential*; females only-negative pregnancy test & contraceptive measures)* ☐ No

11. Is the recipient taking any medications that interact with the requested medication(s) (*check & submit medication list*)?
☐ Yes ☐ No

Request for Olysio combination therapy with interferon and ribavirin

1. Does the recipient have genotype 1a with an NS3 Q80K polymorphism *(submit documentation)*? ☐ Yes ☐ No

Request for Sovaldi without interferon

1. Is the recipient interferon ineligible? ☐ Yes *(submit documentation)* ☐ No

Request for a Non-Preferred Agent

1. Has the Recipient tried and failed the preferred medications (listed above)? ☐ Yes *(submit documentation)* ☐ No

2. Does the Recipient have a contraindication/intolerance to the preferred medications? ☐ Yes (*submit documentation)* ☐ No

Must be obtained within the previous 3 months

PLEASE SEND COMPLETED FORM WITH CLINICAL INFORMATION TO DPW – PHARMACY DIVISION

Prescriber Signature:_____ Date:_____

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