pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

HEPATITIS C AGENTS PRIOR AUTHORIZATION FORM

The prior authorization guidelines for **Hepatitis C Agents** and **Quantity Limits/Daily Dose Limits** can be found on the DHS Pharmacy Services website, accessible at http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		**PRESCRIBER INFORMATION**	
☐New request ☐Renewal request	total # pages: ____________	Prescriber name:	
Name/phone # of office contact:		State license #:	NPI:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication(s) requested:
(check all that apply to request – all agents listed require prior auth)

☐Copegus tab (NP)	☐Mavyret[PA]	☐Peg-Intron (NP)	☐Sovaldi (NP)	☐Vosevi (NP)
☐Daklinza (NP)	☐Moderiba tab (NP)	☐Rebetol (NP)	☐Technivie (NP)	☐Zepatier[PA]
☐Epclusa[PA]	☐Olysio (NP)	☐Ribasphere Ribapak (NP)	☐Viekira Pak (NP)	☐____________
☐Harvoni*[PA]	☐Pegasys (NP)	☐Ribasphere tablet (NP)	☐Viekira XR (NP)	______________

(NP) denotes agent is non-preferred; *[PA] denotes an agent is preferred and requires a clinical prior authorization

Drug #1:	Directions:	Qty:	Refills:
Drug #2:	Directions:	Qty:	Refills:

Specialty Pharmacy Drug Program: Which specialty pharmacy will be used? ☐Diplomat Specialty Pharmacy ☐Walgreen's Specialty Pharmacy

1. What is the beneficiary's genotype? ☐1a ☐1b ☐2 ☐3 ☐4 ☐5 ☐6 Date of testing: ______________ *Submit documentation of test results.*
2. What is the beneficiary's baseline viral load? _________________ Date of testing: ______________ *Submit documentation of results within past 3 months.*
3. Does the beneficiary have results of RAS (resistance-associated substitutions) testing? ☐Yes – *Submit documentation of results.* ☐No
4. Does the beneficiary have results of recent kidney function testing and Metavir fibrosis score? ☐Yes – *Submit documentation of results.* ☐No
5. Is the beneficiary taking any medications that interact with the medication(s) being requested? ☐Yes ☐No *Submit beneficiary's complete medication list.*
6. Was the beneficiary previously treated for hepatitis C? ☐Yes ☐No *Submit documentation of previous treatment regimen, treatment dates, lab work, and treatment outcome. Include results of NS5A RAS screening for all DAA treatment failures.*
7. Does the beneficiary have a history of substance abuse or dependency? ☐Yes ☐No *Submit documentation of prescriber counseling regarding the risks of alcohol or IV drug abuse and an offer of a referral for substance use disorder treatment.*
8. Does the beneficiary have documentation of receipt of the hepatitis B vaccination series or results of hepatitis B screening (HBsAg, anti-HBs, and anti-HBc)? ☐Yes ☐No *Submit documentation of vaccination or screening results.*
9. ***If positive for hepatitis B sAg (HBsAg)***, does the beneficiary have results of quantitative HBV DNA testing? ☐Yes ☐No *Submit documentation of test results. If positive, submit plan for hep B treatment. If negative, submit plan for hep B vaccination.*
10. Does the beneficiary have results of HIV screening (HIV Ag/Ab)? ☐Yes – *Submit documentation of test results.* ☐No
11. ***If confirmed positive by HIV-1/HIV-2 antibody differentiation immunoassay***, is the beneficiary being treated for HIV infection? ☐Yes ☐No *Submit documentation of HIV treatment or rationale for not treating.*
12. Does the beneficiary have documented commitment to adherence with the planned course of treatment and mutual monitoring by the prescriber and the Department? ☐Yes ☐No
    Direct contact information for office hepatitis C contact (REQUIRED):
    Name: ____
    Phone #: ____
    Email: ____
13. Will the beneficiary be taking ribavirin? ☐Yes – *Submit documentation of CBC with differential (within past 3 months) and, if female, a recent negative pregnancy test and contraceptive measures that will be used.* ☐No
14. ***For requests for NON-PREFERRED agents***, has the beneficiary tried and failed, or have a contraindication or intolerance to, the preferred agents listed below in the same drug class/type as the requested non-preferred agent?
    Preferred direct acting antivirals
    ☐Epclusa*[PA] ☐Mavyret*[PA]
    ☐Harvoni*[PA] ☐Zepatier*[PA]
    Preferred ribavirins
    ☐Ribasphere or ribavirin 200mg capsule
    ☐ribavirin tablet
    ☐Yes – *Submit documentation of contraindication, intolerance, or drug regimen tried and failed.*
    ☐No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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