INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
HEPATITIS C AGENTS PRIOR AUTHORIZATION (PA) REQUEST FORM

CareSource Pharmacy Prior Authorization Form
P.O. Box 8738
Dayton, OH 45401-8738
Fax: (866) 930-0019

Today's Date ☐☐ ☐☐☐ ☐☐☐☐ Non-Urgent ☐ Urgent ☐

Note: The prescribing provider must complete this form.
****All sections must be completed or the request will be returned****

Patient's CareSource ID # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's Indiana License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Office Contact
Prescriber Fax ☐☐☐ - ☐☐☐ - ☐☐☐☐	Prescriber Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐
Prescriber's Address	Date(s) of service: _____ Start Date: _____

Requested Medication & Strength	Quantity	Directions for Use	Genotype

Is PA request for DIRECT-ACTING ANTIVIRAL (DAA) RETREATMENT (treatment failure or re-infection)? ☐ Yes ☐ No

If **YES**, retreatment requested due to:

□ **Treatment failure, due to:**
- □ Incomplete therapy resulting from intolerance to previous therapy
  - Number of days completed with original treatment _____
  - Provide documentation for HCV RNA results (quantitative) throughout treatment and SVR 12 (if applicable)
- □ Not compliant with previous therapy
  - Number of days completed with original treatment _____

- Provide documentation for HCV RNA results (quantitative) throughout treatment and SVR 12 (if applicable)

□ Insufficient or unstained response to completed therapy (copy of a completed MedWatch form submitted to FDA documenting treatment failure must attached to PA request)

- Provide documentation for HCV RNA results (quantitative) throughout treatment and SVR 12 (if applicable)

□ **Re-infection (member previously cured and virus re-introduced), due to:**

□ Organ transplant or blood transfusion (must provide documentation of transplant/transfusion)

□ Other (must provide documentation demonstrating actions taken to prevent reinfection in the future)

If **NO,** requesting to treat a DAA treatment-naïve patient with either:

□ A non-preferred agent

□ A formulation with specific age and/or weight criteria (e.g., pellet formulations)

Diagnosis Code: _____

Note: *Provide documentation regarding current AND previous genotype(s) respective to infection(s); previous therapies; member compliance; ALL HCV RNA results (quantitative and qualitative) obtained during and after treatment or when considering retreatment (labs must be within 6 months of prior authorization request date). Retreatment consideration for non-compliance or re-infection will be subject to medical review. Please include actions being taken by both provider and member to support prevention of non-compliance or reinfection.*

Has member previously utilized any of the below agents? □ Yes, complete chart below □ No

Previous Trial Drug Name	Date	Reason for stopping medication
Daklinza (daclatasvir dihydrochloride)		
Epclusa (sofosbuvir/velpatasvir)		
Harvoni (ledipasvir/sofosbuvir)		
Mavyret (glecaprevir/pibrentasvir)		
Olysio (simeprevir sodium)		
Sovaldi (sofosbuvir)		
Technivie (ombitasvir/paritaprevir/ritonavir)		

Previous Trial Drug Name	Date	Reason for stopping medication
Viekira(dasabuvir/ombitasvir/paritaprevir/ritonavir)		
Vosevi (sofosbuvir/velpatasvir/voxilaprevir)		
Zepatier (elbasvir/grazoprevir)		

Preferred Agents

If the request is for sofosbuvir/velpatasvir 400-100 mg, Epclusa 200-50 mg, Epclusa 150-37.5 mg, Mavyret, or Zepatier:

1. Please select agent being requested:
   - □ Sofosbuvir/Velpatasvir 400-100 mg tablet
   - □ Epclusa 200-50 mg tablet
   - □ Epclusa 200-50 mg oral pellet packet
   - □ Epclusa 150-37.5 mg oral pellet packet
   - □ Mavyret 100-40 mg tablet
   - □ Mavyret 50-20 mg oral pellet packet
   - □ Zepatier 50-100 mg tablet

2. Member age: _____

3. Member weight (please specify kg/lbs): _____

4. Previous hepatitis C treatments that member has tried and failed (please complete retreatment section above:)

5. List patient specific factors relevant to the requested treatment or treatment duration (e.g., ribavirin ineligible, compensated or decompensated cirrhosis, baseline NS5A polymorphisms, etc.):

_____
_____
_____

Non-Preferred Agents

If the request is for brand Harvoni or generic ledipasvir/sofosbuvir:

1. Please select agent being requested:
   - □ Harvoni 45-200 mg tablet
   - □ Harvoni 90-200 mg tablet
   - □ ledipasvir/sofobuvir 90-400 mg tablet
   - □ Harvoni 45-200 mg oral pellet packet
   - □ Harvoni 33.75-150 mg oral pellet packet

2. Member age: _____

If the request is for brand Harvoni or generic ledipasvir/sofosbuvir (continued):

3. Member weight (please specify kg/lbs): _____

4. Previous hepatitis C treatments that member has tried and failed (complete retreatment section above):

_____

5. List patient specific factors relevant to the requested treatment or treatment duration (e.g., ribavirin ineligible, compensated or decompensated cirrhosis, baseline NS5A polymorphisms, etc.):

_____
_____
_____

6. Medical justification for use of Harvoni or ledipasvir/sofosbuvir over preferred agents:

_____
_____
_____

If the request is for brand name Epclusa 400-100 mg tablet:

1. Member age: _____

2. Member weight (please specify kg/lbs): _____

3. Previous hepatitis C treatments that member has tried and failed (complete retreatment section above):

_____

4. Any patient specific factors relevant to the requested treatment or treatment duration (e.g., ribavirin ineligible, compensated or decompensated cirrhosis, baseline NS5A polymorphisms, etc.):

_____
_____
_____

5. Medical justification for use of brand Epclusa over sofosbuvir/velpatasvir (if applicable):

_____
_____
_____

If the request is for brand Sovaldi:

1. Please select agent being requested:
   - □ Sovaldi 200 mg tablet
   - □ Sovaldi 400 mg tablet
   - □ Sovaldi 150 mg oral pellet packet
   - □ Sovaldi 200 mg oral pellet packet

2. Member age: _____

3. Member weight (please specify kg/lbs): _____

If the request is for brand Sovaldi (continued):

4. Previous hepatitis C treatments that member has tried and failed (please complete retreatment section above):

_____

5. Any patient specific factors relevant to the requested treatment or treatment duration (e.g., ribavirin ineligible, compensated or decompensated cirrhosis, baseline NS5A polymorphisms, etc.):

_____
_____
_____

6. Medical justification for use of Sovaldi over preferred agents:

_____
_____
_____

If the request is for brand Vosevi:

1. Member is 18 years of age or older? □ Yes □ No

2. Member has a diagnosis of hepatitis C genotype 1, 2, 3, 4, 5 or 6? □ Yes □ No

3. Select one of the following:
   - □ Member has hepatitis C genotype 3 with prior treatment failure of a regimen containing NS5B inhibitor (sofosbuvir) OR NS5A inhibitor (elbasvir, pibrentasvir)
   - □ Member has hepatitis C genotype 1, 2, 3, 4, 5 or 6 with prior treatment failure with an NS5A inhibitor plus NS3/4 PI regimen (e.g., ombitasvir/partiaprevir/ritonavir/dasabuvir OR elbasvir/grazoprevir)
   - □ Member has hepatitis C genotype 1, 2, 4, 5 or 6 with prior treatment failure of a regimen Containing NS5B inhibitor (sofosbuvir) or NS5A inhibitor (elbasvir, pibrentasvir) AND Medical justification for use of Vosevi over Mavyret:

_____

4. Dose requested is one 400-100-100mg tablet daily? □ Yes □ No

5. Does the member have decompensated cirrhosis (Child-Pugh Class B or C)? □ Yes □ No
   Note: Members with decompensated cirrhosis will be denied.

6. Previous hepatitis C treatments that member has tried and failed (please complete retreatment section above):

_____

Any patient specific factors relevant to the requested treatment or treatment duration (e.g., ribavirin ineligible, compensated or decompensated cirrhosis, baseline NS5A polymorphisms, etc.):

_____
_____
_____

I attest that the information provided on this form is accurate:

Physician Signature: _____ **Date:** _____