CareSource

Hepatitis C Treatment Prior Authorization Form

Phone: 1-800-488-0134
Fax: 1-866-930-0019

Patient Information

Patient Name:_____Date: _____
CareSource ID: _____ Patient DOB: _____
Patient's Address: _____City/State/Zip: _____
Patient's Phone Number: (____)_____

Medication Information

Medication & Strength:_____
Directions: _____
Quantity: _____ Duration of Therapy: _____
Refills:_____

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Refills:_____

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Directions: _____
Quantity: _____ Duration of Therapy: _____
Refills: _____

Physician Signature*:_____Date: _____

***By signing above the physician is providing a prescription that can be used to facilitate dispensing and/or coordination of delivery for the requested medication.**

Clinical Information

Documentation from the medical record including test results, lab reports medication history must be submitted to support answers below. <u>The genotype report, fibrosis level report and negative urine toxicology screen(s) MUST be provided or the prior authorization cannot be processed.</u>

1. Does the patient have a diagnosis of chronic hepatitis C? ☐ Yes ☐ No
2. What genotype does the patient have? (submit lab results from the past 6 months with PA request)
   1 2 3 4 5 6
3. If a subtype was detected please note here (e.g. a,b): _____
4. Is the medication prescribed by a specialist (i.e. gastroenterologist, hepatologist, or infectious disease)? ☐ Yes ☐ No
5. Is the patient treatment naïve? (If yes skip to question 10)
   ☐ Yes ☐ No ☐ Unsure
6. Is this a request to extend or continue therapy from another plan? ☐ Yes ☐ No
   If yes, how long is the requested extention?_____
7. Has the patient been previously treated with a sofosbuvir-based regimen (Sovaldi, Harvoni)? ☐ Yes ☐ No
   If yes, which medication(s) and how long?_____
8. Has the patient been previously treated with an oral protease inhibitor (Incivek, Victrelis, or Olysio)?
   ☐ Yes ☐ No If yes, which medication(s) and how long?_____

9. Has the patient been previously treated Peg interferon & ribavirin? ☐ Yes ☐ No
   If yes, how long?_____

10. Was the patient compliant with previous treatment regimens? ☐ Yes ☐ No
    If no, why was therapy stopped?

11. Does the patient have stage 3 or greater hepatic fibrosis level? (submit lab results with PA request)
    ☐ Yes ☐ No

12. Does the patient have cirrhosis? ☐ Yes ☐ No

13. Does the patient have Hepatocellular Carcinoma that meets Milan Criteria and is awaiting liver transplantation? ☐ Yes ☐ No

14. Has the patient had a liver transplant? ☐ Yes ☐ No

15. Does the patient have HIV-1 co-infection and compliant with antiretroviral therapy? ☐ Yes ☐ No

16. Is the patient a previous abuser of illicit drugs or alcohol?
    ☐ Yes ☐ No (If no skip to question 18)

17. Is the patient a previous abuser of alcohol and have 3 consecutive monthly negative urine toxicology screens (drug & alcohol) in the last 120 days? (submit lab results with PA request)
    ☐ Yes ☐ No ☐ N/A

18. Has the patient had a negative urine toxicology screen (drug& alcohol) within the last 60 days? (submit lab results with PA request) ☐ Yes ☐ No

19. Has the patient had a baseline HCV-RNA greater than 50 IU/ml within the last 6 months? ☐ Yes ☐ No

Prescribing Physician Information

Physician Name: _____ Specialty: _____
DEA #: _____ NPI #: _____
Address: _____ City/State/Zip: _____
Phone Number: (_____) _____ Fax Number: (_____) _____
Office Contact: _____

Dispensing Information

Requested Dispensing Specialty Pharmacy: _____
Phone Number: _____ Fax Number: _____
NPI or Tax ID: _____ Address: _____

Criteria are based on CareSource Medical Policy. Approved prior authorizations are contingent upon the eligibility of the member at the time of service and the claim timely fill limits. Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits.