

HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM HEPATITIS C DIRECT ACTING ANTIVIRALS

ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, Mavyret®, Sovaldi®, Viekira Pak®, Vosevi®, Zepatier®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ledipasvir/sofosbuvir (Harvoni® authorized generic), sofosbuvir/velpatasvir (Epclusa® authorized generic),
 Mavyret® (glecaprevir/pibrentasvir)

Non-Formulary: Sovaldi® (sofosbuvir), Viekira Pak® (ombitasvir/paritaprevir/ritonavir and dasabuvir),
 Vosevi® (sofosbuvir/velpatasvir/voxilaprevir), Zepatier® (elbasvir/grazoprevir)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
For use in Hepatitis C Virus (HCV) infection			
1. Is the requesting prescriber a gastroenterologist, hepatologist, transplant specialist, infectious disease specialist, or a provider registered with Project ECHO-HCV (Extension for Community Healthcare Outcomes)?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a documented diagnosis of chronic HCV infection with documentation of a positive qualitative HCV RNA test?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Does documentation include a quantitative viral load?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Has the member's HCV genotype been obtained? • Not required for Sofosbuvir/velpatasvir (Epclusa® authorized generic)	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Does the member have current issues with compliance?	<input type="checkbox"/>	<input type="checkbox"/>	
6. If the member has a psychiatric condition, is the member currently stable and adequately managed?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
7. If the request is for Mavyret, does the member have moderate or severe impairment (Child-Pugh class B or C)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

For use in retreatment of Hepatitis C Virus (HCV) infection			
1. Is the requesting prescriber a gastroenterologist, hepatologist, transplant specialist, infectious disease specialist, or a provider registered with Project ECHO-HCV (Extension for Community Healthcare Outcomes)?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a documented diagnosis of chronic HCV infection with documentation of a positive qualitative HCV RNA test?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Does documentation include a quantitative viral load?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. If the member had a sofosbuvir-based treatment failures, is the request for the preferred agent Mavyret?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. If the member had a Mavyret treatment failure, is the request for Vosevi?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

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Policy: PHARM-CHIP-030
 Origination Date: 07/01/2024
 Reviewed/Revised Date:
 Next Review Date:
 Current Effective Date: 07/01/2024

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