PRIOR AUTHORIZATION REQUEST: Hepatitis C Treatment

Please fax form to Amida Care: 1-646-786-0997

MEMBER INFORMATION	
Name:	Medicaid ID #:
Phone #:	Address:
PRESCRIBER INFORMATION	
Name:	NPI:
Office Phone #:	Office Fax #:
Address:	
Contact Person:	

Please Choose One or More Prescriber Specialty:

Prescriber Specialty: ☐ Hepatologist ☐ Gastroenterologist ☐ Transplant ☐ Infectious Disease ☐ Other _____

FORMULARY PREFERRED OPTIONS

Select	Indication	Presence of Cirrhosis	Medication Requested	Duration
☐	Genotype 1, 2, 3, 4, 5,or 6: **Treatment Naïve**	Without cirrhosis	glecaprevir/pibrentasvir (Mavyret®)	8 weeks
☐	Genotype 1, 2, 3, 4, 5,or 6: **Treatment Naïve**	Without cirrhosis or compensated cirrhosis	velpatasvir/sofosbuvir (ag Epclusa*)	12 weeks
☐	Genotype 1, 2, 3, 4, 5,or 6: **Treatment Naïve**	With decompensated cirrhosis	velpatasvir/sofosbuvir (ag Epclusa*) + Ribavirin	12 weeks
☐	Genotype 1, 2, 4, 5, or 6: **Treatment experienced with IFN + RBV +/- sofosbuvir**	Without cirrhosis	glecaprevir/pibrentasvir (Mavyret®)	8 weeks
☐	Genotype 1, 2, 3, 4, 5, or 6: **Treatment experienced with IFN + RBV +/- sofosbuvir**	Without cirrhosis	velpatasvir/sofosbuvir (ag Epclusa*)	12 weeks
☐	Genotype 1, 2, 4, 5, or 6: **Treatment experienced with IFN + RBV +/- sofosbuvir**	With decompensated cirrhosis	velpatasvir/sofosbuvir (ag Epclusa*)	12 weeks
☐	Genotype 3: **Treatment experienced with IFN + RBV +/- sofosbuvir**	With decompensated cirrhosis	velpatasvir/sofosbuvir (ag Epclusa*) + Ribavirin	12 weeks
☐	Genotype 1, 2, 3, 4, 5, or 6: **Treatment experienced with IFN + RBV +/- sofosbuvir**	With decompensated cirrhosis	velpatasvir/sofosbuvir (ag Epclusa*) + Ribavirin	12 weeks
☐	Genotype 1: **Treatment experienced with NS3/4A PI without prior NS5A inhibitor**	Without cirrhosis	velpatasvir/sofosbuvir (ag Epclusa*)	12 weeks
☐	Genotype 1: **Treatment experienced with NS3/4A PI without prior NS5A inhibitor**	Without cirrhosis or compensated cirrhosis	velpatasvir/sofosbuvir (ag Epclusa*) + Ribavirin	12 weeks
☐	Genotype 1: **Treatment experienced with NS5A inhibitor without prior NS3/4A PI**	Without cirrhosis or with compensated cirrhosis	glecaprevir/pibrentasvir (Mavyret®)	16 weeks

**The authorized generic form of Epclusa (velpatasvir/sofosbuvir) is the preferred formulary agent*

☐ **Clinical Rationale required for non-preferred (non-formulary) drug with documentation of contraindication to Epclusa or Mavyret:**

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Treatment Readiness: (documentation required)

☐ Patient demonstration of readiness, willingness, and ability to adhere to the regimen

Education Readiness: (documentation required)

☐ Patient understands reinfection of Hepatitis C is still possible after being cured of Hepatitis C

☐ Patient understands not to engage in risky and unhealthy behaviors which would lead to reinfection.

*****Amida Care resources are available to support member adherence and lifestyle modification. Please check below to request any additional type of support or services for member:***

☐ Additional support needed for member by Amida Care (Please specify type of support or education needed):

_____

_____

MEDICAL DIAGNOSIS AND CLINICAL CRITERIA

Please provide labs/documentation required for verification of questions

1. Hep C Genotype:_____
2. Most recent Baseline HCV RNA Viral titer/Viral Load (within 3 months): _____
3. What is the patient's prior treatment status?

☐ Treatment Naïve ☐Prior Relapse ☐Prior Partial Responder ☐Null Responder ☐Reinfection

PRIOR HEP C TREATMENT	DURATION/YEAR	OUTCOME OF TREATMENT
	/	
	/	
	/	

4. **Please provide documentation of most recent lab values for CD4 and HIV viral load.*(Check appropriate box.)***

☐Patient on ARVs and recent viral load under 200 copies/mL with CD4 count above 200

☐Patient electing not to be on ARVs and CD4 above 500

☐Neither (**Please provide *explanation* and documentation)**

5. **Please provide documentation of Hepatitis B virus (HBV) status:**

☐HBV negative ☐Concurrent HBV is being treated ☐Neither (**Please provide *explanation* and documentation)**

6. **Has the patient had a liver enzyme level test and either a liver biopsy, Fibroscan or Fibrosure diagnostic test?**

Please provide documentation demonstrating liver enzyme levels and stage of liver fibrosis or cirrhosis.

☐ YES ☐NO **If cirrhosis is present please check**: ☐ Child Pugh ☐ Child Pugh B ☐Child Pugh C

7. **Does the prescriber agree to submit HCV-RNA levels at 4 weeks, end of treatment and 3 months post treatment (12 week SVR)?**

☐YES ☐NO *If **NO**, please explain:*_____

Please call 646-757-7615 or email dgreenidge@amidacareny.org M-F, 9:00-4:30 PM with questions or additional info. You may also provide us with your contact information and the best time to reach you in the space at the top of this document.

_____ _____

Prescriber or Authorized Signature Date