1. **Complete all 3 (three) pages of this form. Incomplete forms will be returned.**
2. **Attach required genotype results and biopsy results or other fibrosis test results.**
3. **Return form and supporting documentation to 410-424-4607 or 410-424-4751.**
4. **Questions? Contact Priority Partners Pharmacy Review at 888-819-1043, option 4.**

PRIORITY PARTNERS
HEPATITIS C THERAPY PRIOR AUTHORIZATION FORM: Page 1 of 3

Patient Information

Recipient:		MA#:
Date of Birth:	Phone #:	Body Weight:

Treatment Plan

☐ Sovaldi ® (sofosbuvir) 400mg:	Take once daily for __________weeks
☐ Harvoni ®:	Take _____tablet(s) once daily for ________weeks
☐ Viekira Pak ™:	Take as directed for __________weeks
☐ Ribavirin __________mg:	Take _____in the morning
☐ Peginterferon alfa __________mcg:	Inject once weekly for __________weeks
☐ Zepatier™:	Take 1 tablet once daily for __________weeks
☐ Epclusa®:	Take 1 tablet once daily for __________weeks
☐ Mavyret®:	Take 3 tablets once daily for __________weeks
☐ Vosevi®:	Take 1 tablet once daily for _________weeks

☐ **Adherence with prescribed therapy is a condition for payment of therapy for up to the allowed timeframe for each HCV genotype.**

Has a treatment plan been developed and discussed with patient? ☐ No ☐ Yes

Does the patient have any history of medication non-adherence?
☐ No ☐ Yes; If yes, please explain:

Diagnosis

☐ Acute Hep C	☐ Chronic Hep C	☐ Hepatocellular Carcinoma
☐ Liver transplant recipient:	Genotype of pre-transplant liver: ______________________________	
	Genotype of post-transplant liver: _____________________________	

☐ Other: ____

What is the patient's HCV Genotype and subtype? ____

Has a liver biopsy been performed? ☐ No ☐ Yes; Test Date: _____/_____/_____

Has a fibrosis test been performed: ☐ No

☐ Yes; Test used: __________; Test Date: _____/_____/_____

Metavir Grade: ______________; Metavir Stage: _____________

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5.

Please provide a copy of the results of the biopsy, genotype and any other fibrosis tests for this patient*

What best describes this patient's liver disease? (Check all that apply):

☐ No cirrhosis ☐ Compensated cirrhosis ☐ Decompensated liver disease

Hepatitis C Treatment History

Has this patient been treated for Hepatitis C in the past: ☐ Treatment Naïve ☐ Treatment Experienced

If treatment experienced, what was the outcome of the previous treatments:

☐ Relapsed ☐ Partial Responder ☐ Non-responder ☐ Toxicities

HCV Regimen	Treatment duration/dates	Treatment Outcome
		☐ Relapsed ☐ Partial Responder ☐ Non-responder ☐ Toxicities ☐ Other: ________________
		☐ Relapsed ☐ Partial Responder ☐ Non-responder ☐ Toxicities ☐ Other: ________________

Laboratory Results

Baseline HCV RNA level (within 180* days of treatment): _________________Date: _____/_____/_____

*unless the patient is cirrhotic, then the baseline lab values must be within 90 days of prior authorization request

Baseline AST: ____________________Baseline ALT: ____________________ Date: _____/_____/_____

Baseline hemoglobin: ______________Baseline Hematocrit: ________________Date: ____/_____/____

Baseline platelet:___________________ Date:_____/______/______

Additional requirement for cirrhotic patient: Baseline total bilirubin____________Date:___/____/____

Baseline albumin:_____________ Date: ___/____/____ Baseline INR:__________ Date: ___/____/____

Medical History

Is the patient co-infected with HIV? No ☐ Yes ☐

If yes, HIV viral load: ________________Date drawn: ______/__/__

Is the patient HBV Positive? No ☐ Yes ☐

If yes, HBV viral load: ________________Date drawn: ________/__/___

Is the patient co-infected with other viral infection? No ☐ Yes ☐

If yes, explain: __________________________

Has the patient had a solid organ transplant? ☐ No ☐ Yes;

If yes, specify type of transplant: ____________________Date of transplant: ____/_____/____

Substance Use History

Does the patient have an active diagnosis of a substance use disorder? ☐ Yes ☐ No

If YES, is the patient actively engaged in treatment? ☐ Yes ☐ No

If NO, please indicate whether an adherence assessment has been done to assure successful treatment completion: ☐ Yes ☐ No

If the patient's Medicaid eligibility changes during therapy and the patient is no longer eligible for Medicaid prescription drug assistance, is the physician prepared to enroll the patient in other patient assisted drug programs to complete therapy? ☐ **Yes** ☐ **No**

I certify that the information provided is accurate. Supporting documentation is available for State audits.

______________________________ ______________________________ ____________________

Prescriber Signature Prescriber Name Date

Practice Specialty: ______________________________Prescriber Phone: ______________________________

Practice Address: ____Prescriber Fax: __________________

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS HEALTHCARE

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HEPATITIS C TREATMENT PLAN: Page 3 of 3

Patient's Name:______________________________________ DOB:_____________________

Genotype (including subtype):______________☐____________

Medications: Please indicate drugs, dose and duration:
(Take or use medications as directed, do not skip a dose)
☐Sovaldi ® (sofosbuvir) 400mg: – Take once daily for _weeks
☐Harvoni ®: --Take ___________tablet(s) once daily for _____weeks
☐ Viekira Pak ™: -Take as directed for __________weeks
☐ Ribavirin__________mg – Take ___________in the morning and ___________in the afternoon for
☐ Peginterferon alfa __________mcg: -- Inject once weekly for ___________weeks
☐ Zepatier™:--Take once daily for __________weeks
☐ Epclusa®:--Take once daily for __________weeks
☐ Mavyret®:--Take three tablets once daily for __________weeks
☐ Vosevi®:--Take once daily for ________weeks

<u>Laboratory Testing – Indicate week during which labs should be completed</u>

HCV levels must be obtained at Treatment weeks 4, 12 and 24 (if necessary)

Week 4 - ____(please insert due date)
Week 12 - ____(please insert due date)
Week 24 (if indicated) - ____(please insert due date)
SVR upon completion of therapy - _______________________________________(please insert due date)

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MEDICINE
JOHNS HOPKINS
HEALTHCARE

This form is for provider's reference only and does not need to be returned to the health plan*

HCV Prior Authorization Provider Checklist

Dear Provider,

In order to facilitate the approval of medications to treat your patient's HCV, please utilize the following checklist to ensure you have included all necessary documentation.

For start of treatment:

☐ Completed PA form

☐ Completed treatment plan (recommended not required for initial therapy

☐ Baseline lab values (within last 180 days unless the patient is cirrhotic; then the baseline lab values must be within 90 days of prior authorization request)

☐ HCV Genotype

☐ Fibrosis score documentation (fibrosure or biopsy results)

☐ Recent (within last 6 months) provider note unless the patient is cirrhotic; then the provider note must be within 90 days of prior authorization request

For refill authorization:

In order to continue on the HCV therapy, patient is required to have follow-up labs.

☐ Lab values between 2 to 4 weeks after initiation of therapy

☐ Lab values after 12 weeks of therapy (for 24 week treatment)

In cases of retreatment, additional viral load values will be requested at week 2 and 6.