PROCARE RX PBM SERVICES/JAI MEDICAL SYSTEMS MANAGED CARE ORGANIZATION, INC.
Call Clinical Services Department at 1-800-555-8513 or Fax 1-800-583-6010. ProCare Rx will respond by fax or phone within 24 hours of receipt of this request.

HEPATITIS C THERAPY PRIOR AUTHORIZATION FORM

Incomplete forms will be returned

Please attach copies of the patient's medical history summary, lab and genetic test reports, and signed treatment agreement form and treatment plan.
****Please review our clinical criteria before submitting this form. ****

Patient Information

Recipient: _____ MA#: _____

Date of Birth: _____/_____/_____ Phone #: (_____) _____ - _____ Body Weight: _____ kg

Treatment

If requesting a non-preferred treatment, please specify why preferred treatments are not appropriate

□ Mavyret (Preferred for all genotypes): Take _____daily for _____ weeks

□ Vosevi (Retreatment only): Take _____daily for _____ weeks

□ _____: Take _____daily for _____ weeks

□ _____: Take _____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 below the details of non-adherence and how will it be addressed:

_____

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: _____

Child Pugh Score (required for treatment of some patients with cirrhosis): _____

If you are asking for an exception of the fibrosis criteria based on coinfection, please see Medical History on Page 2

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

□ No cirrhosis □ Compensated cirrhosis □ Decompensated liver disease

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

Hepatitis C Treatment History

Has this patient been treated for Hepatitis C in the past: □ Treatment Naive □ Treatment Experienced

If Treatment Experienced, what was the outcome of the previous treatments:

□ Relapsed □ Partial Responder □ Non-Responder □ Toxicities

Genotype pre-DAA therapy: _____ Genotype post-DAA therapy: _____

Please indicate what prior regimen(s) the patient has been treated with:

HCV regimen	Treatment duration/ dates	Treatment Outcome
		□ Relapsed □ Partial Responder □ Non-Responder □ Toxicities □ Other: _____
		□ Relapsed □ Partial Responder □ Non-Responder □ Toxicities □ Other: _____

Laboratory Results (Recent = 90 days prior to submission of this form)

Recent baseline HCV RNA level (up to and including 90 days prior): _____ Date:_____/_____/_____

For all regimens please attach recent AST, ALT, total bilirubin and albumin.

For requests for Zepatier for Genotype 1a, please include NS5A resistance test results.

If a regimen is prescribed containing Sovaldi®, Harvoni® or Epclusa ®, please attach recent serum creatinine AND/OR eGFR.

If a regimen is prescribed containing ribavirin, please attach recent hemoglobin, hematocrit and platelet count.

Medical History (Recent = 6 months prior to submission of this form)

Is the patient co-infected with HIV? □ No □ Yes; If yes, state the patient's recent HIV viral load? _____
Date drawn: _____

Is the patient co-infected with HBV? □ No □ Yes; If yes, state the patient's recent HBV viral load? _____
Date drawn: _____

Has patient had a solid organ transplant? □ No □ Yes; If yes, specify what 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, Please provide detail assessment plan:_____
_____

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 assistant drug programs to complete therapy? □ Yes □ No

I certify that the information provided on this form is true and accurate to the best of my knowledge.

_____

Prescriber's signature Prescriber's Name Date

Telephone# (_____) – _____- _____ Fax# (_____) - _____ - _____

Practice Specialty: _____

Address: _____