

HEPATITIS C DIRECT ACTING ANTIVIRALS

PRIOR AUTHORIZATION REQUEST

PRESCRIBER FAX FORM

ONLY the prescriber or clinic personnel may complete this form. This form is for prospective, concurrent, and retrospective reviews

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information, please visit the Blue Cross Blue Shield of North Dakota web site at www.bcbsnd.com.

PATIENT AND INSURANCE INFORMATION		Today's Date: _____	
		Date of Service (if differs from Today's Date): _____	
Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:		Group Number:	

PRESCRIBER/CLINIC INFORMATION			
Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient diagnosis: <input type="checkbox"/> Hepatitis C genotype 1 <input type="checkbox"/> Hepatitis C genotype 2 <input type="checkbox"/> Hepatitis C genotype 3 <input type="checkbox"/> Hepatitis C genotype 4 <input type="checkbox"/> Hepatitis C genotype 5 <input type="checkbox"/> Hepatitis C genotype 6 <input type="checkbox"/> Hepatocellular carcinoma secondary to chronic hepatitis C <input type="checkbox"/> Other (ICD code and description): _____			
Please specify all agents in the requested regimen: _____ Strength: _____ Dosing Schedule: _____ Duration of treatment (weeks): _____ _____ Strength: _____ Dosing Schedule: _____ Duration of treatment (weeks): _____ _____ Strength: _____ Dosing Schedule: _____ Duration of treatment (weeks): _____			
All requests:			
1. What is the patient's weight? _____ kg			
2. Is the patient currently treated with the requested agent within the past 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, when was treatment with the requested agent started? _____			
If yes, how many weeks of therapy has the patient received? _____			
3. Does the patient have any FDA labeled contraindications to the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No			
4. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., gastroenterologist, hepatologist, infectious disease), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No			
5. Is the patient's age within FDA labeling for the requested indication for the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If no, please give information supporting the use of the requested agent for the patient's age for the requested indication: _____			
6. Is the patient treatment naïve? <input type="checkbox"/> Yes <input type="checkbox"/> No			
7. Was the patient previously treated (i.e., treatment experienced) with ONLY peg-interferon and ribavirin with an HCV protease inhibitor? <input type="checkbox"/> Yes <input type="checkbox"/> No			
8. Was the patient previously treated (i.e., treatment experienced) with ONLY peg-interferon and ribavirin without an HCV protease inhibitor? <input type="checkbox"/> Yes <input type="checkbox"/> No			
9. Has the prescriber screened the patient for current or prior hepatitis B viral (HBV) infection? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, was the screening for HBV positive? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, will the prescriber monitor the patient for HBV flare-up or reactivation during and after treatment with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No			
10. Does the patient have cirrhosis? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, does the patient have compensated (Child-Turcotte-Pugh A) cirrhosis? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, does the patient have decompensated (Child-Turcotte-Pugh B or C) cirrhosis? <input type="checkbox"/> Yes <input type="checkbox"/> No			
11. Does the patient have a history of liver transplantation? <input type="checkbox"/> Yes <input type="checkbox"/> No			
12. Does the patient have a history of kidney transplantation? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please continue to the next page.			

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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13. Does the patient have an HIV infection? ☐ Yes ☐ No

14. Is the patient ribavirin ineligible (i.e., patients with a history of intolerance, contraindication, or hypersensitivity to ribavirin)? ☐ Yes ☐ No

Epclusa (sofosbuvir/velpatasvir) requests:

15. Did prior sofosbuvir- or NS5A inhibitor (e.g., daclatasvir, elbasvir, ledipasvir, ombitasvir, velpatasvir) -based treatment fail? ☐ Yes ☐ No

16. Is the requested quantity TWO or more per day of Epclusa 200 mg/50 mg packets OR tablets? ☐ Yes ☐ No
 If yes, please give information supporting why the patient cannot take 1 tablet of the 400 mg/100mg tablet: _____

Harvoni and Ledipasvir/Sofosbuvir requests:

17. Does the patient have genotype 1? ☐ Yes ☐ No
 If yes, please provide the patient's baseline HCV RNA level: _____
 If yes, does the patient have an initial viral load of < 6 M IU/mL? ☐ Yes ☐ No
 If yes, is the patient black or African-American (the patient's ethnicity is requested due to information from the American Association for the Study of Liver Disease clinical practice guidelines for medical care of patients with Hepatitis C)? ☐ Yes ☐ No

18. Was the patient previously treated with sofosbuvir-based treatment failure? ☐ Yes ☐ No

19. Is the requested quantity TWO or more per day of Harvoni 45 mg/200 mg packets OR tablets? ☐ Yes ☐ No
 If yes, please give information supporting why the patient cannot take 1 tablet of Harvoni 90 mg/400 mg strength: _____

Mavyret (glecaprevir/pibrentasvir) requests:

20. Is the requested quantity SIX or more per day of Mavyret 50 mg/20 mg packets? ☐ Yes ☐ No
 If yes, please provide information supporting why the patient cannot take 3 tablets of the 100 mg/40 mg tablet: _____

21. Is the patient treatment experienced with an NS5A inhibitor (e.g., daclatasvir, elbasvir, ledipasvir, ombitasvir, velpatasvir) but without prior treatment with an NS3/4A protease inhibitor (PI)? ☐ Yes ☐ No

22. Is the patient treatment experienced with PRS (i.e., Prior treatment experience with regimens containing interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A PI or NS5A inhibitor)? ☐ Yes ☐ No

Sovaldi (sofosbuvir) requests:

23. Is the patient interferon ineligible defined as one or more of the following: Intolerance to interferon, Autoimmune hepatitis and other autoimmune disorders, Hypersensitivity to PEG interferon or any of its components, Decompensated hepatic disease, Major uncontrolled depressive illness, A baseline neutrophil count below 1500/ μ L, A baseline platelet count below 90,000/ μ L, A baseline hemoglobin below 10 g/dL, or A history of preexisting cardiac disease)? ☐ Yes ☐ No

24. Has the patient failed an interferon based regimen with or without ribavirin? ☐ Yes ☐ No

25. Is the patient awaiting liver transplantation? ☐ Yes ☐ No

26. Is the patient an adult and has a diagnosis of hepatocellular carcinoma secondary to chronic hepatitis C genotype 1, 2, 3, or 4? ☐ Yes ☐ No
 If no, has the patient been treated with the requested agent in the past 30 days? ☐ Yes ☐ No
 If no, does the patient have an intolerance or hypersensitivity to ALL preferred agents (genotype 1 or 4: Epclusa, Harvoni, ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, Mavyret, Vosevi; genotype 2 or 3: Epclusa, sofosbuvir/velpatasvir, Mavyret, Vosevi) for the patient's specific factors (e.g., age, genotype, cirrhosis status, treatment naïve vs treatment experienced, previous treatment) ☐ Yes ☐ No
 If yes, please explain: _____

 If no, does the patient have an FDA labeled contraindication to ALL of the preferred agents (genotype 1 or 4: Epclusa, Harvoni, ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, Mavyret, Vosevi; genotype 2 or 3: Epclusa, sofosbuvir/velpatasvir, Mavyret, Vosevi) for the patient's specific factors (e.g., age and/or weight, genotype, cirrhosis status, and previous treatment)? ☐ Yes ☐ No
 If yes, please specify: _____

Please continue to the next page.

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If no, is there information supporting the use of the requested agent over the preferred agents (genotype 1 or 4: Epclusa, Harvoni, ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, Mavyret, Vosevi; genotype 2 or 3: Epclusa, sofosbuvir/velpatasvir, Mavyret, Vosevi)? ☐ Yes ☐ No
 If yes, please explain: _____

27. Is the patient a pediatric patient with a diagnosis of hepatocellular carcinoma secondary to chronic hepatitis C genotype 2 or 3? ☐ Yes ☐ No
 If no, does the patient have an intolerance or hypersensitivity to BOTH Epclusa and Mavyret? ☐ Yes ☐ No
 If yes, please explain: _____

If no, does the patient have an FDA labeled contraindication to BOTH Epclusa and Mavyret? ☐ Yes ☐ No
 If yes, please specify: _____

If no, is there information supporting the use of the requested agent over BOTH Epclusa and Mavyret (e.g., the patient is currently taking the requested agent)? ☐ Yes ☐ No
 If yes, please explain: _____

28. Is the requested quantity TWO per day or more of Sovaldi 200 mg tablets or packets? ☐ Yes ☐ No
 If yes, provide information stating why the patient cannot take 1 tablet of Sovaldi 400 mg strength: _____

Viekira (ombitasvir/paritaprevir/ritonavir/dasabuvir) PAK requests:

29. Does the patient have normal hepatic function (i.e. Metavir less than or equal to 2)? ☐ Yes ☐ No

30. Please provide the patient's genotype subtype: _____

31. Does the patient have an intolerance or hypersensitivity to ALL of the preferred agents (Epclusa, Harvoni, ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, Mavyret, Vosevi) for the patient's specific factors (e.g., age and/or weight, genotype, cirrhosis status, and previous treatment)? ☐ Yes ☐ No
 If yes, please explain: _____

If no, does the patient have an FDA labeled contraindication to ALL of the preferred agents (Epclusa, Harvoni, ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, Mavyret, Vosevi) for the patient's specific factors (e.g., age and/or weight, genotype, cirrhosis status, and previous treatment)? ☐ Yes ☐ No
 If yes, please explain: _____

If no, is there information to support the use of Viekira over the preferred agents (Epclusa, Harvoni, ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, Mavyret, Vosevi)? ☐ Yes ☐ No
 If yes, please explain: _____

Zepatier (elbasvir/grazoprevir) requests:

32. Does the patient have subtype a? ☐ Yes ☐ No
 If yes, has the prescriber tested the patient for NS5A polymorphisms? ☐ Yes ☐ No
 If yes, does the patient have baseline NS5A polymorphisms at amino acid positions 28, 30, 31 or 93? ☐ Yes ☐ No

33. Does the patient have an intolerance or hypersensitivity to ALL of the preferred agents (Epclusa, Harvoni, ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, Mavyret, Vosevi) for the patient's specific factors (e.g., age and/or weight, genotype, cirrhosis status, and previous treatment)? ☐ Yes ☐ No
 If yes, please explain: _____

If no, does the patient have an FDA labeled contraindication to ALL of the preferred agents (Epclusa, Harvoni, ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, Mavyret, Vosevi) for the patient's specific factors (e.g., age and/or weight, genotype, cirrhosis status, and previous treatment)? ☐ Yes ☐ No
 If yes, please specify: _____

Is there information to support the use of Zepatier over the preferred agents (Epclusa, Harvoni, ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, Mavyret, Vosevi)? ☐ Yes ☐ No
 If yes, please explain: _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Vosevi requests: 34. Was the patients previously treated with an HCV regimen containing an NS5A inhibitor (e.g., daclatasvir, elbasvir, ledipasvir, ombitasvir, velpatasvir)? <input type="checkbox"/> Yes <input type="checkbox"/> No 35. Was the patient previously treated with an HCV regimen containing sofosbuvir without an NS5A inhibitor? <input type="checkbox"/> Yes <input type="checkbox"/> No 36. Does the patient have genotype 1? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify subtype: _____			
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