PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Hepatitis C Agents (Olysio/Sovaldi/Viekira)

Phone: 800-728-7947 **Fax back to: 866-880-4532**

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Select the requested drug and regimen.

- ☐ Sovaldi and Ribavirin x 12 weeks
- ☐ Sovaldi and Ribavirin x 16 weeks
- ☐ Sovaldi and Ribavirin x 24 weeks
- ☐ Sovaldi and Ribavirin and Peginterferon x 12 weeks
- ☐ Other [specify drug name(s), strength(s), regimen, duration]

Q2. If requesting Sovaldi to be used in combination with Daklinza do NOT fill out Sovaldi form. Fill out and submit the Daklinza prior authorization request form ONLY.

Q3. Specify the prescriber's specialty.

- ☐ Hepatologist
- ☐ Board Certified Infectious Disease specialist
- ☐ Board Certified Gastroenterologist
- ☐ Other (please specify)

Q4. Is the patient greater than or equal to 18 years of age?

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☐ Yes ☐ No

Q5. What is the patient's diagnosis?

- ☐ Genotype 1a chronic HCV (or MIXED genotype 1a and 1b)
- ☐ Genotype 1b chronic HCV
- ☐ Genotype 2 chronic HCV
- ☐ Genotype 3 chronic HCV
- ☐ Genotype 4 chronic HCV
- ☐ Other (please specify)

Q6. Please provide ICD code(s) for diagnosis

Q7. Does the patient have an HCV RNA less than 6 million IU / ml?

☐ Yes ☐ No ☐ Unknown

Q8. What is the patient's Metavir score?

- ☐ Metavir score F0
- ☐ Metavir score F1
- ☐ Metavir score F2
- ☐ Metavir score F3 (advanced fibrosis)
- ☐ Metavir score F4 (cirrhosis)
- ☐ Unknown

Q9. How was the patient's Metavir score confirmed? [NOTE: Examples of non-invasive tests include: APRI, FIB-4, FibroIndex, Forns Index, HepaScore/FibroScore, FibroSure, cirrhosis on imaging, ShearWave Elastography, FibroScan, magnetic resonance elastography]

- ☐ Liver biopsy
- ☐ TWO non-invasive tests
- ☐ None of the above

Q10. I have included documentation of the liver biopsy or TWO non-invasive tests used to determine the patient's Metavir score.

☐ Yes ☐ No

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Q11. Select any of the diagnoses below that apply to this patient:

- ☐ Cryoglobulinemia AND either vasculitis, peripheral neuropathy, OR Reynaud's phenomenon
- ☐ Membranoproliferative glomerulonephritis
- ☐ Membranous nephropathy
- ☐ None of the above

Q12. Has the patient had a liver transplant?

☐ Yes ☐ No

Q13. Does the patient have hepatocellular carcinoma (HCC) meeting MILAN criteria, AND is the patient on the liver transplant list?

☐ Yes ☐ No

Q14. Provide MELD score, blood type, and duration of time that patient has been on the transplant list.

Q15. Select any of the following that apply to this patient.

- ☐ Clinically decompensated cirrhosis
- ☐ ESRD on hemodialysis
- ☐ Any other non-liver related comorbidity resulting in less than a 10-year predicted survival
- ☐ Ongoing non-adherence to prior medications or medical treatment
- ☐ Failure to complete HCV disease evaluation, appointments and procedures (e.g. laboratories)
- ☐ None of the above

Q16. Has the patient been abstinent from alcohol and IV drug use for the previous 6 months?

☐ Yes ☐ No

Q17. Select the agents that the patient has been treated with previously:

- ☐ Treatment naive
- ☐ Peginterferon & Ribavirin (Dual Therapy)
- ☐ Daclatasvir (Daklinza)
- ☐ Dasabuvir (Viekira)
- ☐ Elbasvir (Zepatier)
- ☐ Grazoprevir (Zepatier)
- ☐ Ledipasvir (Harvoni)

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- ☐ Ombitasvir (Viekira, Technivie)
- ☐ Paritaprevir (Technivie, Viekira)
- ☐ Simeprevir (Olysio)
- ☐ Sofosbuvir (Sovaldi or Harvoni)
- ☐ Other (Please specify)

Q18. If patient is GENOTYPE 1 and requested drug is SOVALDI, OLYSIO, or VIEKIRA, provide clinical justification as to why the preferred agent, Harvoni, is not appropriate for this patient.

Q19. Additional Comments

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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