PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Technivie (ombitasvir/paritaprevir/ritonavir)

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. Specify the prescriber's specialty.

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

Q2. Is the patient greater than or equal to 18 years of age?

☐ Yes ☐ No

Q3. What is the patient's diagnosis?

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

Q4. Please provide ICD code(s) for diagnosis

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Q5. What is the requested regimen and duration of therapy?

- ☐ Technivie 2 tablets once daily (morning) plus ribavirin for 12 weeks
- ☐ Technivie 2 tablets once daily (morning) without ribavirin for 12 weeks
- ☐ Other

Q6. If you answered "Other" for question 5, please provide requested regimen and duration.

Q7. 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

Q8. 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

Q9. I have included documentation of the liver biopsy or the results of the TWO non-invasive tests used to determine patient's Metavir score.

☐ Yes ☐ No

Q10. 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

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Q11. Has the patient had a liver transplant?

☐ Yes ☐ No

Q12. Does the patient have hepatocellular carcinoma (HCC) meeting MILAN criteria, AND is the patient on the liver transplant list?

☐ Yes ☐ No

Q13. Provide MELD score, blood type, and duration of time that patient has been on the transplant list.

Q14. Has the patient been abstinent from alcohol and IV drug use for the previous 6 months?

☐ Yes ☐ No

Q15. Will ribavirin be taken concomitantly with Technivie?

☐ Yes ☐ No

Q16. If you answered "no" to question 15, please select all of the following that apply to the patient:

- ☐ Woman that is pregnant or may become pregnant
- ☐ Male whose female partner is or may become pregnant
- ☐ Hemoglobinopathy (e.g., thalassemia major or sickle-cell anemia)
- ☐ Co-administration with didanosine
- ☐ Documented history of clinically significant or unstable cardiac or renal disease
- ☐ Documented clinically significant anemia, including clinically significant anemia with prior ribavirin use
- ☐ None of the above

Q17. Select any of the following that apply to this patient.

- ☐ Cirrhosis
- ☐ Moderate or severe hepatic impairment (Child-Pugh class B or C)
- ☐ ESRD on hemodialysis
- ☐ Concurrent use of drugs that are highly dependent on CYP3A for clearance or moderate and strong inducers of CYP3A
- ☐ 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

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Q18. Select the agents that the patient has been treated with previously:

- ☐ Treatment naive
- ☐ Peginterferon and Ribavirin (Dual Therapy)
- ☐ Daclatasvir (Daklinza)
- ☐ Dasabuvir (Viekira)
- ☐ Elbasvir (Zepatier)
- ☐ Grazoprevir (Zepatier)
- ☐ Ledipasvir (Harvoni)
- ☐ Ombitasvir (Viekira, Technivie)
- ☐ Paritaprevir (Viekira, Technivie)
- ☐ Simeprevir (Olysio)
- ☐ Sofosbuvir (Sovaldi or Harvoni)
- ☐ Other (Please Specify)

Q19. Please address why the preferred agents (i.e. Harvoni, Sovaldi) are clinically inappropriate or why the patient would not be able to tolerate the preferred agents.

Q20. 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

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Patient Name:	**Supervising Physician:**

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.