Hepatitis C Virus Direct-Acting Antivirals
Prior Authorization Request Form

For assistance, please call 1-855-552-6028 or fax completed form to 570-271-5610.

Medical documentation may be requested. This form will be returned if not completed in full.

Member Information		Prescriber Information		
Member Name:		Prescriber Name: Prescriber's Specialty:		
Member ID#:		NPI#:		
Address:		Address:		
City:	State:	City:		State:
Home Phone:	Zip:	Office Phone #:	Office Fax #:	Zip:
Sex (circle): M F	DOB:	Contact Person:		

Diagnosis and Medical Information		
Medication:	Strength and Route of Administration:	Frequency:
☐ New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:	Qty:
Height/Weight:	Drug Allergies:	Diagnosis:
Prescriber's Signature:		Date:

Criteria for Initial Prior Authorization

FORM CANNOT BE PROCESSED UNLESS ALL INFORMATION BELOW IS COMPLETE

- Requested HCV treatment regimen (include dose, schedule and duration):
  ____
- Please indicate the member's hepatitis C genotype: ___________________________
- Please indicate the member's liver staging (based on a Fibroscan, Fibrosure or liver biopsy test):____
- Does the member have a limited life expectancy of less than 12 months due to non-liver related comorbid conditions? □ Yes □ No
- Have all drug interactions with the requested Hepatitis C regimen been addressed by the provider? _______ What actions have been taken? _______________________________
  ____

- If requesting a peginterferon-free regimen, when peginterferon is indicated, please check reason for ineligibility:
  ☐ Hypersensitivity to peginterferon or any of its components
  ☐ Prior reaction to peginterferon requiring discontinuation
  ☐ History of depression with suicidality or resulting in hospital admission and the member is currently receiving antidepressant therapy
  ☐ Autoimmune hepatitis and other immune disorders
  ☐ A baseline neutrophil count below 1500/µL, a baseline platelet count below 90,000/µL or baseline hemoglobin below 10 g/dL
  ☐ Decompensated hepatic disease with a MELD (Model for End-Stage Liver Disease) score ≥ 15

- Does member have cirrhosis? ☐ Yes ☐ No
  If yes, does member have decompensated liver disease? ☐ Yes ☐ No

- Is the member co-infected with HIV/AIDS? ☐ Yes ☐ No

- Does member have hepatocellular carcinoma (that meets Milan criteria) and is awaiting liver transplant? ☐ Yes ☐ No

- For Olysio requests ONLY: If the member has genotype 1a, was the member screened for Q80K polymorphism? ☐ Yes ☐ No
  If yes, please list the date and result:____

- Has the member been previously treated for chronic Hepatitis C? ☐ Yes ☐ No
  If yes, please list previous treatment, dates, duration of therapy, and treatment response (partial responder, nonresponder, or relapser):

Regimen	Dates	Duration of Therapy	Treatment Response

  Was member compliant with previous Hepatitis C medication regimen? ☐ Yes ☐ No ☐ N/A

- Have the following lab values been obtained within the last 3 months? (Please attach results)
  Hepatic Function Panel ☐ Yes Date_____________ ☐ No
  Complete Blood Count with differential ☐ Yes Date_____________ ☐ No
  Basic Metabolic Panel ☐ Yes Date_____________ ☐ No
  Baseline HCV RNA Viral Load ☐ Yes Date_____________ ☐ No

- What is the member's glomerular filtration rate? _______ $mL/min/1.73m^2$

- If member is female of childbearing potential, and was prescribed ribavirin, please provide pregnancy test results and date:
  ☐ Positive ☐ Negative ☐ N/A Date:___________________________

- If concurrent ribavirin therapy is indicated and prescribed for male members, is their female partner pregnant or planning a pregnancy? ☐ Yes ☐ No ☐ N/A

- Has the member been instructed to practice effective contraception during therapy and for 6 months following discontinuation of ribavirin treatment?
☐ Yes ☐ No ☐ N/A

- Psychiatric Evaluation (for patients prescribed peginterferon):
  Does member have a history of the following?
  Prior suicide attempt ☐ Yes ☐ No
  Bipolar Disorder ☐ Yes ☐ No
  Major Depressive Disorder ☐ Yes ☐ No
  Schizophrenia ☐ Yes ☐ No
  Substance Dependency Disorder (within the past 3 years) ☐ Yes ☐ No
  Anxiety Disorders ☐ Yes ☐ No
  Borderline Personality Disorder ☐ Yes ☐ No
  Antisocial Personality Disorder ☐ Yes ☐ No

  If the answer to any of the above questions is yes, and patient was prescribed peginterferon, was a psychiatric evaluation performed within 6 months? ☐ Yes ☐ No
  Psychiatrist____________________ Date____________

  Was the member cleared to start hepatitis C treatment by the psychiatrist? ☐ Yes ☐ No

  If the member was prescribed peginterferon and does not have a history of any psychiatric disorder or substance dependency disorder listed above, was a mental health evaluation performed by the prescriber? ☐ Yes ☐ No

- Has the member completed at least 6 months of abstinence from alcohol and illegal controlled substances prior to initiation of treatment? ☐ Yes ☐ No

- Is the member currently being treated for substance dependency? ☐ Yes ☐ No
  If yes, is the member compliant with treatment? ☐ Yes ☐ No

- For ALL members:
  Has a blood alcohol level screen been completed over the past six months? ☐Yes ☐ No

  If yes, please list all results below:

Date	**Result (Negative or Positive)**

Has a urine drug screen been completed over the past six months? ☐ Yes ☐ No

If yes, please list all results below:

Date	Result (Negative or Positive)

- Did the member receive pre-treatment readiness education about hepatitis C treatment expectations by a health care provider? ☐ Yes ☐ No
- Has the member committed in writing to the documented planned course of treatment including anticipated blood tests and visits, during and after treatment ☐ Yes ☐ No
- Is the member agreeable to counseling and monitoring by representatives from Geisinger Health Plan? ☐ Yes ☐ No

Criteria for reauthorization

- For members being treated with therapy that requires reauthorization, please provide the following lab data:

Treatment Week	Date of HCV RNA Viral Load Testing	HCV RNA Viral Load Results
Baseline		
Week 4		
Week 8		
Other		

For Health Plan internal use only:

Date received_____________ Date reviewed__________Request approved: Y / N / NA

Instructions for Completing the Form

1. Submit a separate form for each medication.

2. Complete **ALL** information on the form.
   NOTE: The prescribing physician should, in most cases, complete the form.

3. Please be sure to provide the physician address in a legible format, as it is required for notification.

4. Once form is completed, mail or fax to:

   Geisinger Health Plan
   Attn: Pharmacy Department 32-45
   100 N. Academy Avenue
   Danville, PA 17822
   Fax: 570-271-5610