

# MASSACHUSETTS STANDARD FORM FOR HEPATITIS C MEDICATION PRIOR AUTHORIZATION REQUESTS

*\*Some plans might not accept this form for Medicare or Medicaid requests.*

A. Destination	
Health Plan or Prescription Plan Name: <b>AllWays Health Partners</b>	
Health Plan Phone: <b>866-814-5506</b>	Health Plan Fax: <b>866-249-6155</b>

B. Patient Information		
Patient Name:	DOB:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____
Member ID #:		

C. Prescriber Information	
Prescribing Clinician:	Phone #:
Specialty:	Secure Fax #:
NPI #:	DEA #:
Prescriber Point of Contact Name (POC) (if different than prescriber):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
<b>Prescribing Clinician or Authorized Representative Signature:</b>	
<b>Date:</b>	

D. Medication Information
<b>Check if Expedited Review/Urgent Request:</b> <input type="checkbox"/> (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)
<input type="checkbox"/> Daklinza <input type="checkbox"/> Epclusa <input type="checkbox"/> Harvoni <input type="checkbox"/> Olysio <input type="checkbox"/> Ribavirin Generic <input type="checkbox"/> Ribavirin Branded <input type="checkbox"/> Sovaldi <input type="checkbox"/> Technivie <input type="checkbox"/> Viekira Pak <input type="checkbox"/> Viekira XR <input type="checkbox"/> Zepatier <input type="checkbox"/> Other _____
Requested Duration of Treatment: _____ weeks
Type of Therapy: <input type="checkbox"/> Initial <input type="checkbox"/> Continuation — weeks remaining: _____
Anticipated or actual start date:
Is the medication prescribed by, or in consultation with, a gastroenterologist, infectious disease specialist, or hepatologist? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>For Zepatier only:</b> Has there been confirmation that the patient does not have a genotype 1a with a baseline NS5A polymorphism? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>For Ribavirin only:</b> Does the patient require a dosage form other than generic ribavirin 200 mg capsules or tablets? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify the following: Dosage form requested: _____ Clinical reason for use: _____
Are any of the following statements true? <input type="checkbox"/> Patient is pregnant or plans to become pregnant within 6 months of completing treatment <input type="checkbox"/> Patient is male with a female partner who is pregnant or plans to become pregnant within 6 months of completing treatment <input type="checkbox"/> Patient has contraindications or intolerance to Ribavirin

**E. Patient Clinical Information**

*\*Please refer to plan-specific criteria for details related to required information.*

**Diagnosis:**  B18.2 Hepatitis C (chronic)  Other: \_\_\_\_\_

**HCV Genotype:**  1  1a  1b  2  3  4  5  6

**Stage of Hepatic Fibrosis:**  F0  F1  F2  F3  F4

**If F 4:**  Compensated  Decompensated

**Check all methods of assessment that apply and include result:**

Method	Result
<input type="checkbox"/> Liver biopsy	See above
<input type="checkbox"/> Transient elastography (FibroScan)	_____ kPa
<input type="checkbox"/> Shear wave elastography	_____ kPa
<input type="checkbox"/> MRE	_____ kPa
<input type="checkbox"/> FibroSure (FibroTest)	_____
<input type="checkbox"/> Echosens Fibrometer	_____
<input type="checkbox"/> Fibrospect	_____
<input type="checkbox"/> APRI	_____
<input type="checkbox"/> Fib-4	_____
<input type="checkbox"/> Hepascore	_____
<input type="checkbox"/> Other: _____	_____

Does the patient have HIV coinfection?  Yes  No  Unknown

Is the patient status post liver transplant?  Yes  No

**Confirm the patient's GFR range:**  0-14  15-29  30 or greater (Please specify.) \_\_\_\_\_

**HCV RNA levels:**

Baseline (most recent): \_\_\_\_\_ IU/mL Date of lab work: \_\_\_\_\_

Week 8 of treatment (if continuation request): \_\_\_\_\_ IU/mL Date of lab work: \_\_\_\_\_

**Previous Treatments**

Has the patient been previously treated for Hepatitis C and failed treatment?  Yes  No

Adverse Reaction?  Yes  No

Drug Name	Date of treatment (MM/YY)	Response to treatment
		<input type="checkbox"/> Relapsed <input type="checkbox"/> Partial response <input type="checkbox"/> Null response ( <2 log reduction in HCV RNA at Week 12) <input type="checkbox"/> Did not complete <input type="checkbox"/> Briefly describe details: _____
		<input type="checkbox"/> Relapsed <input type="checkbox"/> Partial response <input type="checkbox"/> Null response ( <2 log reduction in HCV RNA at Week 12) <input type="checkbox"/> Did not complete <input type="checkbox"/> Briefly describe details: _____
		<input type="checkbox"/> Relapsed <input type="checkbox"/> Partial response <input type="checkbox"/> Null response ( <2 log reduction in HCV RNA at Week 12) <input type="checkbox"/> Did not complete <input type="checkbox"/> Briefly describe details: _____

Additional information pertinent to this request:

*Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.*