

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:	
Health Plan Phone:	Health Plan Fax:

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):	
Prescribing Clinician or Authorized Representative Signature:	
Date:	

D. Medication Information

Check if Expedited Review/Urgent Request:
 (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.)

Daklinza Epclusa Harvoni Olysio Ribavirin Generic Ribavirin Branded
 Sovaldi Technivie Viekira Pak Viekira XR Zepatier Other _____

Requested Duration of Treatment: _____ weeks

Type of Therapy: Initial Continuation — weeks remaining: _____

Anticipated or actual start date: _____

Is the medication prescribed by, or in consultation with, a gastroenterologist, infectious disease specialist, or hepatologist? Yes No

For Zepatier only: Has there been confirmation that the patient does not have a genotype 1a with a baseline NS5A polymorphism?
 Yes No Unknown

For Ribavirin only: Does the patient require a dosage form other than generic ribavirin 200 mg capsules or tablets? Yes No
 If yes, please specify the following:
 Dosage form requested: _____
 Clinical reason for use: _____

Are any of the following statements true?

Patient is pregnant or plans to become pregnant within 6 months of completing treatment
 Patient is male with a female partner who is pregnant or plans to become pregnant within 6 months of completing treatment
 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.