UnitedHealthcare Community Plan

Hepatitis C Medications - Nebraska
PRIOR AUTHORIZATION REQUEST FORM

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

- Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: _____
- Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information ***(This form is for Hepatitis C Medications only; for all other drugs please submit a new form)***

Medication 1:	**Strength:**
Directions for use:	**Quality:**
Medication 2:	**Strength:**
Directions for use:	**Quality:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS WITH HEPATITIS C
All supporting labs and chart documentation is required for medical review of this request.

Genotype (Must submit supporting lab documentation)
□ Genotype 1 □ Genotype 2 □ Genotype 3
□ Genotype 4 □ Genotype 5 □ Genotype 6
□ Other Gentoype (Must Specify): _____

Prescriber Specialty:
□ Hepatologist □ Gastroenterologist □ Infectious Disease Specialist □ Transplant Physician
□ Other (Must Specify): _____

□ Yes □ No	**Has this patient been treated for Hepatitis C previously?** *If "Yes", please provide details of previous therapy including names of medications used, dates of therapy, and outcome of treatment / reason for discontinuing:*	**Patient's Weight:** _____ **kg**

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Section D – Previous Medication Trials

Trial	Regimen (*List all medications tried with each trial)*	Dates of Therapy	Treatment Complete	Outcome of Treatment or Reason for Discontinuation
1				
2				

Clinical and Drug Specific Information

The following information below MUST be included upon submission:
□ Medication name, dose, and duration □ ALL labs and/or medical records addressed below
□ Agreement to submit post-treatment viral load data if requested

ALL REQUESTS

□ **Yes** □ **No**	**Is the patient currently on any of the following medications?** *(If yes, check which applies)* □ Daklinza □ Epclusa □ Harvoni □ Olysio □ Sovaldi □ Technivie □ Viekira Pak □ Viekira XR □ Vosevi □ Zepatier
	Please select one of the following: □ Compensated □ Decompensated □ Patient does not have cirrhosis
	What is the duration of treatment: □ 8 weeks □ 12 weeks □ 16 weeks □ 24 weeks □ Other, list: _____ weeks
□ **Yes** □ **No**	**Has the provider submitted evidence of Stage 3 or Stage 4 hepatic fibrosis via one of the following confirmatory tests?** □ Liver biopsy confirming a METAVIR fibrosis score of F3 or F4 □ Other diagnostic evaluation supporting hepatic fibrosis (e.g. Ultrasound-based transient elastography (Fibroscan) score ≥ 9.5 kPa, FibroTest (FibroSURE) score ≥ 0.59, Fibrosis-4 Index (FIB-4) > 3.25, Aspartate aminotransferase/platelet ration index (APRI) score >1.5, Cirrhotic features on imaging, or Physical exam
□ **Yes** □ **No**	**Does the patient have any of the following risk factors?** *(If yes, check all that apply)* □ Hepatocellular carcinoma awaiting transplant □ Co-morbid conditions (HIV OR AIDS, Hepatitis B, Insulin-resistant diabetes type 2) □ Severe extrahepatic complications such as cryoglobulinemia □ Other documentation of immediate need to treat
□ **Yes** □ **No**	**Has a negative standard drug urine screen report been collected within 15 days before date of prior authorization request?** *(Must include with request)*
□ **Yes** □ **No**	**Has the patient been evaluated for past or current history of substance use disorder (SUD) or alcohol abuse, using a standardized model of assessment, such as ASAM criteria?**
□ **Yes** □ **No**	**Has the prescriber attested that patient has been abstinent of alcohol and IV drug use for at least the last 6 months and or evidence of participation in recovery treatment program?**
□ **Yes** □ **No**	**Is there documentation of a treatment plan which includes all the following?** *(If yes, check which apply)* □ Instruction on the prevention of re-infection □ Methods of decreasing the risks of re-infection □ Abstinence from engaging in such activities *(All below MUST be submitted)*
□ **Yes** □ **No**	**Is there documentation of testing for evidence of current or prior hepatitis B virus (HBV) infection before initiating treatment?** *(If yes, check which applies)* □ Patient is HCV/HBV co-infected □ Patient does not have HBV
□ **Yes** □ **No**	**Will the patient be monitored for hepatitis flare or HBV reactivation during HCV treatment and post-treatment follow-up?**
□ **Yes** □ **No**	**Is Epclusa being used in a patient who meets the following: genotype 1-6 with decompensated cirrhosis along with ribavirin?**
□ **Yes** □ **No**	**Is Harvoni being used in a patient who meets ONE of the following:** *(If yes, check which applies)* □ For genotype 1 with decompensated cirrhosis along with ribavirin □ For use in children ages 12 to 17 □ Post liver transplant for genotype 1 or 4

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□ Yes □ No	**Is there documentation of why the preferred product is not appropriate for the patient?** *If yes, list reason and complete Section D above:*
PREP - C	
If PREP-C evaluation from not submitted, a validated screening tool MUST be submitted (i.e., patient must be evaluated for current history of alcohol and substance abuse with a validated screening instrument, such as AUDIT C, CAGE alcohol screen, or NIDA's drug screen tool)	
□ Yes □ No	**Has the patient demonstrated readiness per the Psychosocial Readiness Evaluation and Preparation for Hepatitis C Treatment (PREP-C) free interactive online tool, completed by the prescriber?** *(MUST be submitted if completed)*

NOTE: If PREP-C evaluation from OR other validated screening tool not submitted, ALL of the following MUST be documented in the patient's chart and submitted:

- **Motivation:** Reasons client wants to begin HCV treatment, concerns about treatment, and importance of treatment.
- **Information:** Knowledge about HCV treatment and one's own HCV disease status.
- **Medication Adherence:** Current prescribed medications and adherence to them in prior month.
- **Self-Efficacy:** Self-confidence about adhering to HCV treatment.
- **Social Support and Stability:** Stability of financial, housing, and social support resources.
- **Alcohol and Substance Use:** Alcohol and substance use behaviors and current treatment. Patient must be evaluated for current history of alcohol and substance abuse with a validated screening instrument, such as AUDIT C, CAGE alcohol screen or NIDA's drug screening tool. Patient must be abstinent for past 6 months or more. Lab results demonstrating abstinence must be submitted for coverage periodically throughout treatment.
- **Psychiatric** Stability: Current psychiatric status, previous and current treatment.
- **Energy Level:** Attains adequate sleep and currently lacks signs of fatigue.
- **Cognitive Functioning:** Perceived difficulty with communication in health care setting, problem-solving ability, and memory.

DAKLINZA	
□ Yes □ No	**Does the patient have concomitant use of strong CYP3A inducers (rifampin, phenytoin, carbamazepine, St. John's Wort)?** *If yes, list CYP3A inducer:*
MAVYRET	
□ Yes □ No	**Does the patient have any of the following exclusions: severe hepatic impairment (Child-Pugh C), or taking atazanavir or rifampin?**
□ Yes □ No	**Is the patient treatment-naïve or treatment-experienced?** *(If yes, check which applies)* □ Treatment-naïve □ Treatment-experienced
□ Yes □ No	**If patient is treatment-experienced, is there documentation of previous failure to reach SVR (sustained virologic response)?** ***Please submit documentation with request***
VOSEVI	
□ Yes □ No	**Does the patient without cirrhosis or with compensated cirrhosis (Child-Pugh A)?**
□ Yes □ No	**Has the patient previously been treated with an NS5A inhibitor or sofosbuvir?** *If yes, list previous regimen:*
□ Yes □ No	**Is there documentation of previous failure to reach SVR (sustained virologic response)?**
□ Yes □ No	**Is the patient taking rifampin?**
ZEPATIER	
□ Yes □ No	**Does the patient have HCV Genotype 1a infection?**
	Testing for the presence of virus with NS5A resistance associated polymorphisms is recommended prior to initiation of treatment with Zepatier to determine dosage regimen and duration. □ Acknowledged
□ Yes □ No	**Does the patient have any of the following exclusions:** *(If yes, check which applies)* □ Patient with moderate or severe hepatic impairment (Child-Pugh B or C) □ OATP1B1/3 inhibitors, strong CYP3A inducers and efavirenz

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PEG-INTERFERON AND RIBAVIRIN	
□ Yes □ No	**Is the requested regimen for dual therapy with peg-interferon and ribavirin only?**
□ Yes □ No	**Is the requested regimen approved for the direct acting antiviral (DAA)?** *If yes, list requested regimen:*

Physician Signature: _____ Date: _____