Prior Authorization Form
Hepatitis C- Antiviral Agents

Access this PA form at http://southcarolina.fhsc.com/providers/rxdocuments.asp

If the following information is not complete, correct, or legible, the PA process can be delayed. Use one form per member please.

Member Information

LAST NAME:

FIRST NAME:

ID NUMBER:

DATE OF BIRTH: – –

Prescriber Information

LAST NAME:

FIRST NAME:

NPI NUMBER:

DEA NUMBER:

PHONE NUMBER: – –

FAX NUMBER: – –

Clinical Criteria Documentation

*****Do **not** include documentation that is not requested on this form*****

*****Complete Chart & attach documentation of lab values*****

Laboratory Documentation		
Baseline HCV RNA level		
Week 4 HCV RNA level		
Week 12 HCV RNA level		

1. What is the diagnosis for which this drug is being requested?
   - ☐ Chronic Hepatitis C, genotype 1a
   - ☐ Chronic Hepatitis C, genotype 1b
   - ☐ Other ____

2. For females: Is the patient pregnant? ☐ Yes ☐ No

3. Please check if the patient has any of the following. If yes, documentation must be attached. ☐ Yes ☐ No
   - ☐ Liver biopsy showing Metavir score of F3/F4
   - ☐ Fibrotest (FibroSure) score of ≥ 0.59
   - ☐ Ultrasound based transient elastography (Fibroscan) score ≥ 9.5 kPa
   - ☐ Fibrosis-4 index (FIB-4) > 3.25

4. Please check if the patient has any of the following. If yes, documentation must be attached. ☐ Yes ☐ No
   - ☐ Essential mixed cryoglobulinemia with end organ manifestations
   - ☐ Proteinuria
   - ☐ Nephrotic Syndrome
   - ☐ Membranoproliferative glomerulonephritis

5. Has the patient had prior treatment with dasabuvir/ombitasvir/paritaprevir? ☐ Yes ☐ No

6. Is patient taking concomitant therapy with a hepatitis C protease inhibitor? ☐ Yes ☐ No

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If you have received this transmission in error, please immediately notify us by telephone and return the original message to
SC Medicaid Pharmacy Program, c/o Magellan Health Services, 1103 Broad Street, Suite 500, Glen Allen, VA23060.
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7. Is the patient actively participating in illicit substance or alcohol abuse?(If Yes, Skip to Question#11) ☐ Yes ☐ No

   . ☐ Yes ☐ No

8. Does the patient have a past history of illicit substance or alcohol abuse?
   - If yes, attach confirmation that the patient has completed or is participating in a recovery program, or receiving substance or alcohol abuse counseling services, or seeing an addiction specialist as part of Chronic Hepatitis C treatment ☐ Yes ☐ No
9. Has the patient been free of substance abuse for the previous 6 months? ☐ Yes ☐ No
10. Has the patient been free of alcohol abuse for the previous 6 months? ☐ Yes ☐ No
11. Does the patient have decompensated cirrhosis, defined as a Child-Pugh score of greater than 6 (Class B or C)? ☐ Yes ☐ No
12. Does the patient have a diagnosis of compensated cirrhosis? ☐ Yes ☐ No
13. Will the patient be taking in combination with ribavirin? ☐ Yes ☐ No
14. Please check the box corresponding to the specialty of the prescribing physician:
    ☐ Gastroenterologist
    ☐ Hepatologist
    ☐ Infectious Disease Specialist
    ☐ Other ____
15. Is the patient taking concomitant therapy with any of the following contraindicated medications? If yes, please provide documentation: chart notes, claims history, or statement attesting to current therapy
    alfuzosin, carbamazepine, phenytoin, phenobarbital, gemfibrozil, rifampin, ergotamine, dihydroergotamine, ergonovine, methylergonovine, ethinyl estradiol-containing contraceptives, St. John's wort, lovastatin, simvastatin, pimozide, efavirenz, sildenafil (when dosed for the treatment of pulmonary arterial hypertension), triazolam, orally administered midazolam ☐ Yes ☐ No
16. Is the patient taking concomitant therapy with any of the following potentially significant interacting medications? If yes, please provide supporting documentation: chart notes, claims history, or statement attesting to current therapy (for Viekira): ☐ Yes ☐ No
    - *Antiarrythmics: amiodarone, bepridil, disopyramide, flecainide, lidocaine (systemic), mexiletine, propafenone, quinidine*
    - *Antifungals: ketoconazole, voriconazole*
    - *Calcium Channel Blockers: amlodipine*
    - *Corticosteroids: fluticasone*
    - *Diuretics: furosemide*
    - *HMG CoA Reductase Inhibitors: rosuvastatin, pravastatin*
    - *Immunosuppressants: cyclosporine, tacrolimus*
    - *Narcotic Analgesics: buprenorphine*
    - *Sedatives/Hypnotics: alprazolam*
    - *Proton Pump Inhibitors: omeprazole*
    - *HIV Antivirals: atazanavir/ritonavir, darunavir/ritonavir, lopinavir/ritonavir, rilpivirine*
    - *Long acting beta-agonists: salmeterol*

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17. Is the patient taking concomitant therapy with any of the following potentially interacting medications? If yes, please provide supporting documentation: chart notes, claims history or statement attesting to current therapy. (For Harvoni):

- *Acid Reducing Agents: antacids, PPIs, H2Blockers*
- *Antiarrhythmics: digoxin*
- *HIV Antiretroviral combinations including tenofovir*
- *HCV products: simeprevir*
- *Anticonvulsants: carbamazepine, phenytoin, phenobarbital, oxcarbazepine*
- *Antimycobacterials: rifabutin, rifampin, rifapentine*
- *HIV medications: tipranavir/ritonavir, cobicistat/elvitegravir/emtricitabine/tenofovir*
- *Herbal Supplements: St John's wort*
- *HMG-CoA Reductase Inhibitors: rosuvastatin*

☐ Yes ☐ No

18. Which of the following best describes the patient prior to this course of treatment for hepatitis C?

☐ Treatment naïve

☐ Prior "null responder" (less than a 2 log decrease in HCV-RNA at treatment week 12)

☐ Prior relapser (undetectable HCV RNA at end of previous treatment, but detectable within 24 weeks after treatment)

☐ Prior partial responder (≥ 2 log decrease in HCV RNA at week 12 of previous treatment, but did not achieve undetectable HCV RNA at end of treatment)

19. <u>Preferred Products</u>

☐ (ombitasvir/paritaprevir/ritonavir and dasabuvir (Viekira Pak™) 12.5.75/50mg and 250mg tabs

☐ ribavirin (if patient is unable to take ribavirin, clinical documentation must be included)

<u>Non-Preferred Products</u> ☐ sofusbuvir (Sovaldi ®) 400mg tab

☐ simeprevir (Olysio®) 150mg cap

☐ ledipasvir/sofosbuvir (Harvoni®) 90-400mg tab

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Please note any other information pertinent to this PA request:

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Please Note: If approved, compliance with therapy is required. Authorizations will be terminated for patients who are noncompliant with therapy.

____ ____________________

Prescriber Signature (Required) ***Date***

*(**On behalf of the Prescriber or Pharmacy Provider, I **certify that the information stated above is a true statement, made for the purposes of inducing SC Medicaid to offer prescription coverage to this individual for the medication requested above. I understand that this document and any attached materials will be* ***RETAINED FOR THE PURPOSES OF POSSIBLE FUTURE AUDIT).***

Fax This Form to: 888-603-7696

Phone: 866-247-1181

PA's may be requested online, see the following website for details:

http://southcarolina.fhsc.com/

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