Geisinger Health Plan

Hepatitis C Virus Direct-acting Antivirals Prior Authorization Request Form

For assistance, please call 800-988-4861 or fax completed form to 570-300-2122

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:	Quantity:	No. of refills:
Height/weight:	Drug allergies:	Diagnosis:	
Directions for use:			
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 note, attach NS5A RAS screening if testing is recommended by current AASLD guidelines

- Please indicate the member's Hepatitis C genotype:_____

- 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

- Please indicate the member's liver staging (based on METAVIR liver scoring):_____
  - Documentation enclosed ☐Yes ☐No

- If the member has cirrhosis, has a hepatocellular carcinoma screening been completed? ☐Yes ☐No

- **Please attach** medical record documentation of complete:

  Hepatitis B immunization series
  Documentation enclosed ☐Yes ☐No

  Hepatitis B screening (sAb/sAg and cAb/cAg)
  Documentation enclosed ☐Yes ☐No

  - If positive for Hepatitis B sAg or cAb or cAg, please attach quantitative HBV DNA and

  - If positive for quantitative HBV, please provide HBV treatment

  - If negative for Hepatitis B sAb, **please attach** medical record documentation that member is being vaccinated against HBV.
    Documentation enclosed ☐Yes ☐No

- **Please attach** documented HIV screening (HIV Ag/Ab)
  Documentation enclosed ☐Yes ☐No

  - If confirmed positive by HIV-1/HIV-2 differentiation immunoassay, is member being treated for HIV ☐Yes ☐No
  - If confirmed positive by HIV-1/HIV-2 differentiation immunoassay and member is not being treated for HIV, is medical record documentation of the rationale for not being treated? ☐Yes ☐No

  Provide rationale: _____

- Have all drug interactions caused by the requested Hepatitis C regimen been addressed by the provider? ☐Yes ☐No What actions have been taken?_____

- **Please attach** the following labs that have been obtained <u>within the last 3 months:</u>
  - Hepatic function panel
  - Complete Blood Count with Differential
  - Basic metabolic panel
  - Baseline HCV RNA viral load
    Documentation enclosed ☐Yes ☐No

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

- If using ribavirin: Is member is female of childbearing potential, please provide pregnancy test results:
  Positive Negative N/A

- If using ribavirin: If member is male with a female partner who is of childbearing potential, are they pregnant or planning a pregnancy?
  Yes No N/A

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

Is the member actively abusing alcohol or IV drugs? ☐ Yes ☐ No
Does the member have a history of abuse? ☐ Yes ☐ No
If yes to either question above, is there documentation of the prescriber counseling regarding the risks of alcohol or IV drug abuse? ☐ Yes ☐ No
If yes to either question above, is there documentation of an offer of a referral for substance use disorder treatment? ☐ Yes ☐ No

• Did the member receive pre-treatment readiness education about hepatitis C treatment expectations by a healthcare provider? ☐ Yes ☐ No

• Has the member committed to the documented planned course of treatment including anticipated blood tests and visits, during and after treatment? ☐ Yes ☐ No

• Does the member have a limited life expectancy of less than 12 months due to non-liver- related co-morbid conditions? ☐ Yes ☐ No

- Please note, if prior authorization is approved, Geisinger Health Plan requires SVR12 –viral RNA labs 12 weeks after treatment—**faxed to 570-300-2122. Attn: Hepatitis C Pharmacist**

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: 570-300-2122