Geisinger Health Plan

Geisinger GHP Family

# Hepatitis C Virus Direct-acting Antivirals Prior Authorization Request Form

**For assistance, please call 800-988-4861 or fax completed form to 570-271-5610**

Medical documentation may be requested. This form will be returned if not completed in full.

| **Member information** | | **Prescriber information** | | |
|---|---|---|---|---|
| Member name: | | Prescriber name:<br><br>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 indicate the member's Hepatitis C genotype:

  _____

- Please indicate the member's liver staging (based on METAVIR liver scoring):

  _____

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

- Does member have a documented completion of Hepatitis B immunization series or Hepatitis B screening (sAb/sAg and cAb/cAg)? ☐Yes ☐No
    - If positive for Hepatitis BsAg or cAb or cAg, is there detectable HBV DNA and will member be treated for Hepatitis B; or, if negative for hepatitis BsAb, is member being vaccinated against Hepatitis B? ☐Yes ☐No
- Does member have a documented HIV screening (HIV Ag/Ab)? ☐Yes ☐No
    - If confirmed positive by HIV-1/HIV-2 differentiation immunoassay, is member being treated for HIV; or is member not being treated for HIV and there is medical record documentation of the rationale for not being treated? ☐Yes ☐No
- Have all drug interactions caused by the requested Hepatitis C regimen been addressed by the provider? ☐Yes ☐No What actions have been taken?_____
  _____
- Does member have signs and symptoms of decompensated liver disease? ☐Yes ☐No
- Does member have hepatocellular carcinoma (that meets Milan criteria) and is awaiting liver transplant? ☐Yes ☐No
- 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 |
|---|---|---|---|
| | | | |
| | | | |

- Have the following lab values been obtained within the last 3 months? (Please attach results)
  Hepatic function panel ☐Yes Date_____ ☐No
  Complete blood count with differential ☐Yes Date_____ ☐No
  Basic metabolic panel ☐Yes Date_____ ☐No
  Baseline HCV RNA viral load ☐Yes Date_____ ☐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

- If the member is actively abusing alcohol or IV drugs, or has a history of abuse, is there documentation of the prescriber counseling regarding the risks of alcohol or IV drug abuse, and 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 complete and return the following information for members being treated with hepatitis C therapy with a duration longer than 12 weeks, requiring reauthorization:

| **Treatment week** | **Date of HCV RNA viral load testing** | **HCV RNA viral load results** |
|---|---|---|
| Baseline | | |
| Week 4 | | |
| Week 8 | | |
| Week 12 | | |
| Week 24 | | |

**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: 570-271-5610