

## 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:		
Member ID#:			Prescriber's specialty:		
Address:			NPI#:		
City:			Address:		
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:	
<input type="checkbox"/> 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.					
<ul style="list-style-type: none"> <li>Requested HCV treatment regimen (include dose, schedule and duration): _____</li> <li>Please indicate the member's Hepatitis C genotype: _____</li> <li>Please indicate the member's liver staging (based on METAVIR liver scoring): _____</li> <li>If the member has cirrhosis, has a hepatocellular carcinoma screening been completed? <input type="checkbox"/>Yes <input type="checkbox"/>No</li> </ul>					

- 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<sup>2</sup>
- 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