GEISINGER HEALTH PLAN

Geisinger

Hepatitis C Virus Direct-acting Antivirals Prior Authorization Request Form

For assistance, 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 specialty:		
Member ID#:			NPI# (if available):		
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:	Qty:

Height/weight:	Drug allergies:	Diagnosis:
No. of refills:	Directions for use:	
Prescriber's signature:		Date:

Criteria for initial prior authorization
FORM CANNOT BE PROCESSED UNLESS ALL INFORMATION BELOW IS COMPLETE.

- If resistance testing is recommended by current AASLD guidelines, is documentation of NS5A RAS screening attached? ☐ Yes ☐ No ☐ N/A

- What is 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

- What is member's liver staging (based on METAVIR liver scoring)? _____

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

- Have all drug interactions associated with the requested hepatitis C agent been addressed by the provider? ☐ Yes ☐ No
  - What actions have been taken? _____
    _____

- What are the results of HIV screening (HIV Ag/Ab)? ☐ Positive ☐ Negative Date: _____
  - If positive for HIV-1/HIV-2 as confirmed by differentiation immunoassay, what is the treatment regimen or rationale for non-treatment? _____
    _____

- Has the member completed a hepatitis B (HBV) immunization series? ☐ Yes ☐ No
    - If member has not completed a hepatitis B immunization series, the following labs are required:

Screening	Result	Date
Hepatitis B sAb	☐ Positive ☐ Negative	
Hepatitis B sAg	☐ Positive ☐ Negative	
Hepatitis B cAb	☐ Positive ☐ Negative	
HBV DNA (only if positive for hepatitis B sAg)	IU/mL	

    - If member is positive for active hepatitis B infection with a detectable HBV DNA, what is the HBV treatment regimen? _____
    - If member does not have active hepatitis B infection or history or immunization, when will immunization series begin? _____

- Attach the following labs dated within the past 3 months to request:

Screening	Date
Hepatic function panel	
Complete blood count with differential	
Basic metabolic panel	
Baseline HCV RNA viral load	

- If using ribavirin and member is of childbearing potential, what are the results of pregnancy screening? ☐ Positive ☐ Negative ☐ N/A

- If using ribavirin and 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? ☐ Yes ☐ No ☐ N/A

- Is the member actively abusing alcohol or IV drugs? ☐ Yes ☐ No

- Does the member have a history of abusing alcohol or IV drugs? ☐ Yes ☐ No

- If the member is actively abusing or has a history of abusing, is there documentation of prescriber counseling regarding the risks of alcohol and/or IV drug abuse? ☐ Yes ☐ No ☐ N/A

- If the member is actively abusing or has a history of abusing, is there documentation of an offer of referral for substance use disorder treatment? ☐ Yes ☐ No ☐ N/A

- Has the member received pre-treatment readiness education about hepatitis C treatment expectations from a healthcare provider? ☐ Yes ☐ No

- Has the member committed to the documented planned course of treatment including anticipated blood tests and visits both 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 to be submitted 12 weeks after treatment completion. Fax to (570) 300-2122, Attention Hepatitis C Pharmacist.

Request for expedited review

☐ REQUEST FOR EXPEDITED REVIEW [24 HOURS]

→ BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING FOR THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

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