Geisinger Health Plan

Hepatitis C Virus Direct-Acting Antivirals
Prior Authorization Request Form

For assistance, please call 1-800-988-4861. 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: 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:	Qty:
Height/Weight:	Drug Allergies:	Diagnosis:
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 the member have severe extrahepatic manifestations of hepatitis C (such as but not limited to a syndrome involving cryoglobulinemia, an immune complex disorder, and a lymphoproliferative disorder that produces arthralgias, fatigue, palpable purpura, renal disease, neurologic disease, and reduced complement levels, as well as symptoms or objective evidence of end organ damage), HIV, or HBV coinfection, or history of a liver

transplant? ☐ Yes ☐No If yes, please describe _____

- Have all drug interactions caused by the requested Hepatitis C regimen been addressed by the provider? _____ What actions have been taken? _____

- Does member have signs and symptoms of decompensated liver disease? ☐ Yes ☐No
- Is the member co-infected with HIV/AIDS? ☐ 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
  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 and member is female of childbearing potential: please provide pregnancy test results and date:
  ☐ Positive ☐Negative ☐ N/A Date:_____
- 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 treatment?
  ☐ Yes ☐No ☐N/A
- Psychiatric Evaluation: Does member have a history of the following if requesting interferon?
  Prior suicide attempt ☐ Yes ☐No
  Bipolar Disorder ☐ Yes ☐No
  Major Depressive Disorder ☐ Yes ☐No
  Schizophrenia ☐ Yes ☐No
  Substance Dependency Disorder (within the past 3 years) ☐ Yes ☐No

Anxiety Disorders ☐ Yes ☐No
Borderline Personality Disorder ☐ Yes ☐No
Antisocial Personality Disorder ☐ Yes ☐No

If the answer to any of the above questions is yes, was a psychiatric evaluation performed within 6 months? ☐ Yes ☐No Psychiatrist_____
Date_____
Was the member cleared to start hepatitis C treatment by the psychiatrist? ☐ Yes ☐No

If the member does not have a history of any psychiatric disorder or substance dependency disorder listed above, was a mental health evaluation performed by the prescriber? ☐ Yes ☐No

- Has the member completed at least 6 months of complete abstinence from alcohol and illegal controlled substances prior to initiation of treatment? (does not apply to GHP Family members) ☐ Yes ☐No

- Is the member currently being treated for substance dependency? (does not apply to GHP Family members) ☐ Yes ☐No
  If yes, is the member compliant with treatment? ☐ Yes ☐No

- Has a blood alcohol level screen been completed prior to initiation of treatment? (does not apply to GHP Family members) ☐ Yes ☐No

If yes, please list all results below:

Date	Result (Negative or Positive)

- Has a urine drug screen been completed prior to initiation of treatment? (does not apply to GHP Family members) ☐ Yes ☐No

If yes, please list all results below:

Date	Result (Negative or Positive)

- 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? (For GHP Family members only) ☐ Yes ☐No

- Does the urine drug screen (UDS) correctly correspond with medication fill history? (does not apply to GHP Family members) ☐ Yes ☐No
- Did the member receive pre-treatment readiness education about hepatitis C treatment expectations by a health care 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
- Is the member agreeable to counseling and monitoring by representatives from Geisinger Health Plan? ☐ 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