GHP Family Pharmacy Customer Service
100 N. Academy Ave.
Danville, PA 17822
Tel. • 855•552•6028 PA Relay 711 GeisingerHealthPlan.com

Geisinger

# HEPATITS C AGENTS PRIOR AUTHORIZATION FORM *(form effective 01/05/2021)*

Prior authorization guidelines for Hepatitis C Agents and Quantity Limits/Daily Dose Limits are available on Geisinger Health Plan's website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

| | | | |
|---|---|---|---|
| ☐ New request ☐ Renewal request | Total # pages: _____ | Prescriber name: | |
| Name/Phone of office contact: | | State license #: | NPI: |
| Facility contact/phone: | | Street address: | |
| Beneficiary name: | | Suite #: | City/state/zip: |
| Beneficiary ID#: | DOB: | Phone: | Fax: |

CLINICAL INFORMATION

| | | | |
|---|---|---|---|
| Requested drug #1: | Directions & Length of Therapy | Quantity: | Refills: |
| Requested drug #2: | Directions & Length of Therapy | Quantity: | Refills: |

**SUBMIT DOCUMENTATION from the medical record for all items below.**

| | | | |
|---|---|---|---|
| Genotype: | Date of testing: | Baseline viral load: | Date of testing: |

| | |
|---|---|
| Beneficiary's complete medication list: | |
| Does the beneficiary have results of RAS (resistance-associated substitutions) testing as recommended by the AASLD? | ☐ Yes – *Submit documentation* ☐ No Not applicable |
| Does the beneficiary have results Metavir fibrosis score? | ☐ Yes – *Submit documentation* ☐ No Metavir Fibrosis Score: _____ |
| Does the beneficiary have results of HIV screening (HIV Ag/Ab)? | ☐ Yes – *Submit documentation* ☐ No |
| *If confirmed positive by HIV-1/HIV-2 antibody differentiation immunoassay*, is the beneficiary being treated for HIV infection or is there documentation of for the beneficiary not being treated? | ☐ Yes ☐ No *Submit documentation of HIV treatment or rationale for not treating.* |
| Does the beneficiary have documentation of receipt of the hepatitis B vaccination series | ☐ Yes ☐ No *Submit documentation of vaccination or screening results.* |
| Does the beneficiary have documentation of results of hepatitis B screening (HBsAg, anti-HBs, and anti-HBc)? | ☐ Yes ☐ No *Submit documentation of test results. vaccination.* |
| Is the beneficiary positive for for hepatitis B sAg?<br>If yes, is there documentation of results of quantitative HBV DNA results?<br>If there is detectable HBV DNA, is there documentation of a treatment plan for hepatitis B consistent with AASLD recommendations? | ☐ Yes ☐ No<br>☐ Yes ☐ No *Submit documentation*<br>☐ Yes ☐ No *Submit documentation of treatment plan* |
| What is the result of the beneficiary's hepatitis B sAb result?<br>If negative for hepatitis B sAb, is there documentation of a hepatitis B immunization plan or counseling to receive the hepatitis B immunization series? | ☐ Positive ☐ Negative *Submit documentation of Results*<br>☐ Yes ☐ No *Submit documetation of plan* |
| Is the beneficiary treatment naïve for hepatitis C?<br>If treatment experienced, is there documentation of the beneficiary's previous treatment regimen? | ☐ Yes ☐ No<br>☐ Yes ☐ No *Submit documentation of previous regimen, dates, lab work, and treatment outcome.* |
| Does the beneficiary have a life expectancy of less than 12 months due to non-liver-related comorbid conditions? | ☐ Yes ☐ No |
| Have all potential drug interactions been addressed by the prescriber (such as discontinuation of the interacting drug, dose reduction of the interacting drug, or counseling of the beneficiary of the risks associated with the use of both medications when they interact)? | ☐ Yes ☐ No *Submit documentation of the drug interaction and how the interaction will be addressed.* |

GHP Family Pharmacy Customer Service
100 N. Academy Ave.
Danville, PA 17822
Tel. • 855•552•6028 PA Relay 711 GeisingerHealthPlan.com

Geisinger

| | | |
|---|---|---|
| Does the beneficiary have documented commitment to adherence with the planned course of treatment and mutual monitoring by the prescriber and the Department? | ☐ Yes<br>☐ No | Direct contact information for office hepatitis C contact (REQUIRED):<br>Name: _____<br>Phone #: _____<br>Email: _____ |
| For requests for NON-PREFERRED agents: Please list the preferred Hepatitis C Agents that the beneficiary has had a therapeutic failure, contraindication, or intolerance to that is appropriate for the beneficiary's genotype according to peer-reviewed medical literature. *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in each class* | | |

**Please submit to PromptPA https://ghp.promptpa.com OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.**

| | |
|---|---|
| Prescriber Signature: | Date: |