**OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.**
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

# Hepatitis C Prior Authorization Request Form (Page 1 of 2)

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED**

## Member Information (required)

| | | |
|---|---|---|
| Member Name: | | |
| Insurance ID#: | | |
| Date of Birth: | | |
| Street Address: | | |
| City: | State: | Zip: |
| Phone: | | |

## Provider Information (required)

| | | |
|---|---|---|
| Provider Name: | | |
| NPI#: | Specialty: | |
| Office Phone: | | |
| Office Fax: | | |
| Office Street Address: | | |
| City: | State: | Zip: |

## Medication Information (required)

| | | |
|---|---|---|
| Medication Name: | Strength: | Dosage Form: |
| ❑ Check if requesting **brand** | Directions for Use: | |
| ❑ Check if request is for **continuation of therapy** | | |

## Clinical Information (required)

**Select the diagnosis below:**

❑ Chronic hepatitis C virus (HCV)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

**Clinical Information:**

Document the hepatitis C virus genotype: _____

Document the baseline hepatitis C virus-RNA level: _____

Is laboratory testing consistent with current AASLD/IDSA guidelines? ❑ **Yes** ❑ **No**

Document the patient's viral load: _____

Select if there is documentation patient has fibrosis from any validated test including, but not limited to:

- ❑ METAVIR
- ❑ Fibrotest
- ❑ Fibrosure
- ❑ Flexi test
- ❑ Fibroscan
- ❑ APRI

**For Daklinza, Epclusa, Harvoni (ledipasvir/sofosbuvir), Olysio, Sovaldi, Technivie, Viekira Pak, Zepatier requests:**

Will documentation be provided confirming the patient has a contraindication, intolerance to, or a failure of sofosbuvir/velpatasvir (unless sofosbuvir/velpatasvir is not indicated)?* ❑ **Yes** ❑ **No**

**Documentation must be provided*

**For Harvoni and Epclusa requests:** Does the patient have documented trial/failure on their generic versions? ❑ **Yes** ❑ **No**

**For new patients:** Is this request for continuation of prior therapy? ❑ **Yes** ❑ **No**

**Patient Readiness and Adherence:**

Has the patient been evaluated for readiness to initiate treatment?* ❑ **Yes** ❑ **No**

**Documentation must be provided*

Is the patient able and willing to strictly adhere to treatment protocols as prescribed by the provider?* ❑ **Yes** ❑ **No**

**Documentation must be provided*

Will caution be exercised if the patient has a history of treatment failure with prior hepatitis C treatment due to non-adherence with treatment regimen and appointments? ❑ **Yes** ❑ **No**

Will the patient be educated regarding potential risks and benefits of hepatitis C virus therapy, as well as the potential for resistance and failed therapy if medication is not taken as prescribed? ❑ **Yes** ❑ **No**

# Hepatitis C Prior Authorization Request Form (Page 2 of 2)

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED**

**Reauthorization/Continuation of Therapy or Retreatment:**

Have all initial criteria (from above) been met? ❑ **Yes** ❑ **No**

Is there evidence of lack of adherence? ❑ **Yes** ❑ **No**

Does the patient have missed medical appointments related to the hepatitis C virus? ❑ **Yes** ❑ **No**

If applicable, is there evidence that retreatment will improve patient outcomes? ❑ **Yes** ❑ **No**

**Populations Unlikely to Benefit from Hepatitis C Virus Treatment:**

Does the patient have a life expectancy less than 12 months? ❑ **Yes** ❑ **No**

According to AASLD/IDSA hepatitis C virus Guidelines, "patients with limited life expectancy for whom hepatitis C virus therapy would not improve symptoms or prognosis do not require treatment. Chronic hepatitis C is associated with a wide range of comorbid conditions. Little evidence exists to support initiation of hepatitis C virus treatment in patients with limited life expectancy (less than 12 months) due to non–liver-related comorbid conditions. For these patients, the benefits of hepatitis C virus treatment are unlikely to be realized, and palliative care strategies should take precedence."

**Criteria for Coverage of Investigational Services:**

Investigational services are not covered except when it is clearly documented that all of the following apply:

- Conventional therapy will not adequately treat the intended patient's condition
- Conventional therapy will not prevent progressive disability or premature death
- The provider of the proposed service has a record of safety and success with it equivalent or superior to that of other providers of the investigational service
- The investigational service is the lowest cost item or service that meets the patient's medical needs and is less costly than all conventional alternatives
- The service is not being performed as a part of a research study protocol
- There is a reasonable expectation that the investigational service will significantly prolong the intended patient's life or will maintain or restore a range of physical and social function suited to activities of daily living
- All investigational services require prior authorization. Payment will not be authorized for investigational services that do not meet the above criteria or for associated inpatient care when a beneficiary needs to be in the hospital primarily because she/he is receiving such non-approved investigational services.

**Unlabeled use of medication:**

Is there reference to current medical literature for the requested unlabeled use? ❑ **Yes** ❑ **No**

Is the medication being used for an unlabeled use and therapy has been consulted with provider organizations, academic and professional specialists? ❑ **Yes** ❑ **No**

**Quantity Limit Requests:**

What is the quantity requested per DAY? _____

**What is the reason for exceeding the plan limitations?**

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

**For continuation of existing therapy, also answer the following:**

Would sudden discontinuation of the dose trigger withdrawal symptoms? ❑ **Yes** ❑ **No**

Would discontinuation of the dose be unsafe for the patient and their condition may worsen or exacerbate? ❑ **Yes** ❑ **No**

Is the prescribing provider attempting to taper or reduce the dose necessary? ❑ **Yes** ❑ **No**

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-297-2870.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.