LOUISIANA HEALTHCARE CONNECTIONS

Phone: 866-399-2928 Fax: 866-399-0929

Hepatitis C Therapy
Prior Authorization Form/ Prescription

Date: _____ Date Medication Required:_____
Ship to: ❍ Physician ❍ Patient's Home ❍ Other _____

Patient Information

Last Name:	First Name:	Middle:	DOB: ____/____/_____
Address:	City:	State:	Zip:
Daytime Phone:	Evening Phone:	Sex: ☐ Male ☐ Female	

Insurance Information (Attach Copies of cards)

Primary Insurance:		Secondary Insurance:	
ID #	Group #	ID#	Group #
City:	State:	City:	State:

Physician Information

Name:	Specialty:	NPI:	
Address:	City:	State:	Zip:
Phone # ( )	Secure Fax # ( )	Office contact:	

Primary Diagnosis

☐ Chronic Hepatitis C ☐ Acute Hepatitis C ☐ Other _____

Genotype ☐1 ☐1a ☐1b ☐2 ☐3 ☐4 ☐5 ☐6

Clinical Information ***** Please submit supporting clinical documentation*****

☐ **INITIAL THERAPY** ☐ **CONTINUATION OF THERAPY**; Therapy start date: _____

Patient's current weight: _____ lbs/kg **BASELINE** HCV-RNA: _____ Date: _____

Provide the patient's **BASELINE** results:

Creatinine clearance _____mL/min OR Serum creatinine_____ Hemoglobin _____ Platelet count _____ Neutrophil count_____

1. Is the patient treatment naïve? ☐ Yes ☐ No if NO, complete the below

Therapy course	Start date (s) (MM/DD/YY)	Pegylated Interferon	Ribavirin	Incivek	Victrelis	Olysio	Sovaldi	Harvoni	Outcome (i.e., null/partial response, relapse, n/a)
Prior treatment (s)									
Current									

****Prior relapse**: HCV RNA not detected at end of prior therapy but detected during follow-up
****Prior partial responder**: 2 log drop in HCV RNA by treatment week 12, but does not become HCV RNA undetectable by end of treatment
****Prior null responder**: Does not achieve a 2 log drop HCV RNA by treatment week 12 of treatment

2. Does the patient have any contraindications to therapy with a protease inhibitor (Incivek, Victrelis, Olysio)? ☐ Yes ☐No
3. Is the infection confirmed by the presence of HCV RNA in the serum within the last 3 months? ☐ Yes ☐No
4. Is therapy being prescribed by a gastroenterologist, hepatologist, or infectious disease specialist? ☐ Yes ☐No
5. Does the patient have documented sobriety from alcohol and/or illicit IV drug for at least 6 months prior to start of therapy? ☐ Yes ☐No
6. Does patient show evidence of advanced liver disease such as fibrosis or cirrhosis? ☐ Yes ☐No
   Assessment method (i.e. biopsy, Firoscan, etc.) _____ Result: _____ ☐F1 ☐F2 ☐F3 ☐F4
7. Does the patient have a diagnosis of hepatocellular carcinoma awaiting transplant? ☐ Yes ☐No
8. Is the patient co-infected with HIV? ☐ Yes ☐No If yes, what is the CD4 count? _____(cells/mm3)

Please continue on page 2.

LOUISIANA HEALTHCARE CONNECTIONS

Phone: 866-399-2928 Fax: 866-399-0929

Hepatitis C Therapy
Prior Authorization Form/ Prescription

Date: _____ Date Medication Required:_____
Ship to: ❍ Physician ❍ Patient's Home ❍ Other _____

Patient name: _____ **DOB:** _____

9. Check which, if any, of the following apply to the patient. **Fax supporting documentation**

- ☐ Pregnancy (self or partner
- ☐ Hemoglobinopathies
- ☐ Hemoglobin < 8.5 g/dL
- ☐ Intolerance/ contraindication to IFN
- ☐ History of depression, or clinical features of depression
- ☐ Decompensated hepatic disease (e.g., Child-Pugh score >6 [class B and C])
- ☐ None of the above
- ☐ History of preexisting cardiac disease
- ☐ Hypersensitivity to PEG or any of its components
- ☐ Autoimmune hepatitis and other autoimmune disorders
- ☐ Unwilling to use adequate contraception (self or partner)
- ☐ Poorly controlled or deteriorating cardiac disease
- ☐ Therapy with Videx (didanosine)

For Sovaldi, Olysio and Harvoni

10. Does patient agree to participate in medication adherence program? ☐ Yes ☐ No
11. Has the patient been engaged with physician in the last 30 days? ☐ Yes ☐ No

For Olysio ONLY

12. Is the NS3 Q80K polymorphism present? ☐ Yes ☐ No

For Harvoni ONLY

13. What is the intended duration of treatment? ☐ 8 weeks ☐ 12 weeks ☐ 24 weeks

For Sovaldi ONLY

14. Does that patient have hepatocellular carcinoma and are currently awaiting liver transplant? ☐ Yes ☐ No
15. **If yes**, does the patient meet MILAN criteria (defined as tumor size ≤ 5cm in diameter with single hepatocellular carcinomas OR 3 tumor nodules or less, each ≤ 3cm in diameter with multiple tumor AND no extra-hepatic manifestations of the cancer or evidence of vascular invasion of tumor? ☐ Yes ☐ No

For Victrelis ONLY,

16. Will patient receive 4 weeks of PEG-IFN and ribavirin prior to starting Victrelis? ☐ Yes ☐ No

CONTINUATION OF THERAPY

****Submit copy of lab results if pertinent to treatment regimen****

Week 4 HCV-RNA: _____ Date: _____ **Week 8 HCV-RNA**: _____ Date: _____
Week 12 HCV-RNA: _____ Date: _____ **Week 24 HCV-RNA**: _____ Date: _____

17. Was the patient poorly interferon responsive (i.e., <1.0-$\log_{10}$ HCV-RNA decline in viral load) at week 4 of treatment? ☐ Yes ☐ No
18. Did patient experience a 2 log drop in HCV-RNA at treatment week 12? ☐ Yes ☐ No
19. Has the patient been engaged with physician in the last 30 days? ☐ Yes ☐ No

Prescription Information

MEDICATION	STRENGTH/DEVICE	DIRECTIONS	QUANTITY	REFILLS
☐ Pegasys				
☐ Peg-Intron				
☐ Victrelis				
☐ Olysio				
☐ Ribavirin				
☐ Sovaldi				
☐ Harvoni				
☐ Other				

Physician's Signature _____ **Date:** _____ ☐ **DAW**