Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Hepatitis Prior Authorization

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician's Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Daklinza 30mg tablets
☐ Daklinza 60mg tablets
☐ Daklinza 90mg tablets
☐ Epclusa 200mg-50mg tablets
☐ Epclusa 400mg-100mg tablets
☐ Harvoni 45mg-200mg tablets
☐ Harvoni 90mg-400mg tablets
☐ Harvoni oral pellets 33.75mg-150mg
☐ Harvoni oral pellets 45mg-200mg
☐ ledipasir/sofosbuvir 90mg-400mg tablets (authorized generic for Harvoni)
☐ Mavyret 100mg-40mg tablets
☐ Sovaldi 200mg tablets
☐ Sovaldi 400mg tablets
☐ Sovaldi oral pellets 150mg
☐ Sovaldi oral pellets 200mg
☐ sofosbuvir/velpatasvir 400mg-100mg tablets (authorized generic for Epclusa)
☐ Viekira Pak
☐ Vosevi
☐ Zepatier 50mg-100mg tablets
☐ Ribavirin 200mg
☐ Rebetrol 200mg capsules
☐ Copegus 200mg tablets

☐ Pegasys 135mcg/0.5mg Proclick
☐ Pegasys 180mcg/0.5mg prefilled syringe
☐ Pegasys 180mcg/0.5ml Proclick
☐ Pegasys 180mcg/1ml vial
☐ Peg-Intron 50mcg/0.5ml vial
☐ Peg-Intron 80mcg/0.5ml vial
☐ Peg-Intron 120mcg/0.5ml vial
☐ Peg-Intron 150mcg/0.5ml vial
☐ Peg-Intron 50mcg/0.5ml Redipen
☐ Peg-Intron 80mcg/0.5ml Redipen
☐ Peg-Intron 120mcg/0.5ml Redipen
☐ Peg-Intron 150mcg/0.5ml Redipen
☐ Intron A 18 million units multidose vial
☐ Intron A 3 million units/dose multidose pen
☐ other (please specify): _____

TREATMENT LENGTH:
☐ 8 weeks
☐ 12 weeks
☐ 16 weeks
☐ 24 weeks
☐ Other (please specify): _____

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use: ICD10:
☐ acute Hepatitis C ☐ chronic Hepatitis C ☐ acute Hepatitis B** ☐ chronic Hepatitis B**
☐ recurrent hepatitis c virus (HCV) post-liver transplantation
☐ Other (please specify): _____
****Please fill out questions found at the bottom of this form****

Clinical Information:
What is the patient's current weight? _____ ☐ lbs ☐ kg

(if not already indicated above) Will your patient also be taking ribavirin? ☐ Yes ☐ No

(if no) Please explain:

For Harvoni 45/200 or Solvaldi 200 (if more than 1 tablet per day) Please provide clinical support for requesting this dosing/quantity for your patient (examples could include past doses tried, past medications tried, pertinent patient history, etc).

FOR HEPATITIS C:

What is the patient's genotype? ☐ 1a ☐ 1b ☐ 1 (unknown subtype)
☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ Other:

Does the patient have HIV/AIDS? ☐ Yes ☐ No

Does the patient have Hepatitis B? ☐ Yes ☐ No

Does the patient have recurrent Hepatitis C following liver transplant? ☐ Yes ☐ No
If yes, is your patient treatment naïve on the allograft liver? ☐ Yes ☐ No

Does the patient have hepatocellular carcinoma (HCC, hepatocellular cancer, malignant hepatoma)? ☐ Yes ☐ No
If yes, has your patient previously had a liver transplant? ☐ Yes ☐ No
If yes, is your patient waiting to undergo a liver transplant? ☐ Yes ☐ No
If yes, does your patient meet MILAN criteria for liver transplantation? ☐ Yes ☐ No

Does your patient have severe renal impairment (a creatinine clearance less than 30 mL/min)? ☐ Yes ☐ No

CIRRHOSIS Information – must be completed

(for **ALL** patients) Documentation MUST be provided of the degree of cirrhosis or hepatic fibrosis by any of the following:
☐ liver biopsy
☐ ultrasound-based transient elastography
☐ specific blood test (for example, FibroTest, FibroSure, etc.)
☐ other (please specify): _____

(if your patient has cirrhosis) Which best describes the patient's grade/Child-Pugh score of hepatic impairment?
☐ Grade A/ score 5-6
☐ Grade B/ score 7-9
☐ Grade C/ score 10-15
☐ unknown – Please provide the following labs:
albumin_____ Date taken:_____

total bilirubin_____ Date taken:_____

INR_____ Date taken:_____

(if patient does NOT have cirrhosis), Please provide either the score and scoring system used (for example: Batts-Ludwig, FibroSure, IASL, Ishak, Knodell, Metavir) _____

OR - the following:
AST _____ Date taken:_____
ALT _____ Date taken:_____
platelets _____ Date taken:_____
albumin _____ Date taken:_____
height _____ weight _____
diabetes: ☐ Yes ☐ No

Provide a list of the patient's current medications (including OTC's): _____

_____

_____

Is your patient committed to participate in a hepatitis C disease state management program? ☐ Yes ☐ No

The following HCV RNA levels are needed for approval of the below corresponding treatments:

Week of Therapy	Level in iu/ml	Date Taken
Pretreatment Baseline**		
4		
8		
12		
24		
other		

****Pretreatment HCV RNA levels should be baseline (e.g. within 3 months of planned therapy initiation).**

Please indicate all drugs the patient has used in previous treatments (tx) or if use is contraindicated:	Stopped tx early (S)* or Completed therapy (C)?	Response: none (N), partial (P), full remission (F)	Relapsed / Recurrence? Y/N	Contraindications to any of these?** Y/N	
☐ Alferon N (interferon alfa-n3)					
☐ Daklinza (daclatasvir)					
☐ Epclusa (sofosbuvir/velpatasvir)					
☐ Harvoni (ledipasvir-sofosbuvir)					
☐ Harvoni oral pellets					
☐ Incivek (telaprevir)					
☐ Intron A (interferon alfa 2b)					
☐ ledipasvir/sofosbuvir (authorized generic for Harvoni)					
☐ Mavyret (glecaprevir/pibrentasvir)					
☐ Pegasys (peginterferon alfa 2a)					
☐ PegIntron (peginterferon alfa 2b)					
☐ Ribavirin					
☐ sofosbuvir/valpatasvir (authorized generic for Epclusa)					
☐ Sovaldi (sofosbuvir)					
☐ Sovaldi oral pellets					
☐ Victrelis (boceprevir)					
☐ Viekira-Pak (ombitasvir/paritaprevir/ritonavir)					
☐ Vosevi (sofosbuvir/velpatas/voxilaprex)					
☐ Zepatier (elbasvir/grazoprevir)					
☐ Other: _____					

***If stopped early, please explain why:**

****If contraindicated, please explain why:**

For **Harvoni** or **ledipasvir/sofosbuvir** (authorized generic for Harvoni) requests:
(if requesting **Harvoni** or its authorized generic and the patient has the following: genotype 1, non-cirrhotic, AND treatment-naïve)
Which of the following applies to this patient?

☐ HIV positive
☐ HCV RNA level 6 million IU/mL or higher
☐ none of the above

For **Vosevi** resquests:
(if requesting **Vosevi** and the patient has genotype 3) Has your patient been screened for Y93H substitution?
☐ yes and detected
☐ yes and NOT detected
☐ no, this testing was not done

For **Zepatier** requests:
(if requesting Zepatier and the patient has genotype 1a) Has your patient been screened for NS5A polymorphism and found to have mutations at codons 28, 30, 31, or 93?
☐ not requesting Zepatier or not genotype 1a
☐ yes, and NS5A polymorphism was detected at codons 28, 30, 31, or 93
☐ yes, and NS5A polymorphism was NOT detected at codons 28, 30, 31, or 93
☐ no, this testing was not done

FOR HEPATITIS B:

What is the patient's genotype?

(if age 3-17 AND new start for Pegasys) Does your patient have Hepatitis B e-antigen (HBeAg)-positive disease? ☐ Yes ☐ No

(if age 3-17 AND new start for Pegasys) Does your patient have evidence of viral replication and elevations in serum alanine aminotransferase (ALT)? ☐ Yes ☐ No

Does the patient have cirrhosis? ☐ Yes ☐ No

(if yes) Which best describes the patient's grade/Child-Pugh score of hepatic impairment?
☐ Grade A/ score 5-6
☐ Grade B/ score 7-9
☐ Grade C/ score 10-15
☐ unknown – Please provide the following labs:

albumin_____ Date taken:_____

total bilirubin_____ Date taken:_____

INR_____ Date taken:_____

Is the patient currently on the requested therapy? ☐ Yes ☐ No

If yes, how many weeks has the patient completed:_____weeks

Date started therapy:_____/_____/_____

For Other Diagnoses:

☐ adult T-cell leukemia/lymphoma (ATLL)
☐ AIDS-related Kaposi sarcoma
☐ chronic myelocytic leukemia (CML)
☐ condylomata acuminata
☐ desmoid tumor (aggressive fibromatosis)
☐ essential thrombocythemia (ET)
☐ follicular lymphoma
☐ giant cell tumor of the bone (GCTB)
☐ hairy cell leukemia
☐ leptomeningeal metastases
☐ melanoma
☐ meningioma
☐ mycosis fungoides (MF)/Sezary syndrome (SS)
☐ myelofibrosis
☐ myeloproliferative disease
☐ polycythemia vera (PV)
☐ renal carcinoma (kidney cancer, renal cancer)
☐ aggressive systemic mastocytosis (ASM)
☐ neuroendocrine tumors of the gastrointestinal tract, lung and thymus (carcinoid tumors)
☐ primary cutaneous CD30+ T-cell lymphoproliferative disorder
☐ other (specify):

(if ATLL) Which of the following applies to your patient?
☐ Intron A is being given as first-line therapy.
☐ Intron A is being given second-line therapy.
☐ other/unknown

(if first-line) Is Intron-A being used in combination with zidovudine (Retrovir)? ☐ Yes ☐ No
(if second-line) Is Intron-A being used in combination with arsenic trioxide (Trisenox)? ☐ Yes ☐ No

(if CML) Which of the following applies to your patient?
☐ Your patient was unable to tolerate one of the following: Bosulif (bosutinib), Gleevec (imatinib), Sprycel (dasatinib), Tasigna (nilotinib).
☐ Patient is post-transplant and relapsed.
☐ other/unknown

(if condylomata) Does your patient have failure, contraindication or intolerance to podofilox (Condylox)? ☐ Yes ☐ No
(if desmoid tumor) Does your patient have primary, recurrent or progressive disease? ☐ Yes ☐ No
(if desmoid tumor or hairy cell leukemia) Will Intron-A be used as single-agent treatment? ☐ Yes ☐ No

(if GCTB) Will Pegasys be used as single-agent therapy? ☐ Yes ☐ No
(if melanoma) Is Intron-A being used as an adjuvant to surgical treatment? ☐ Yes ☐ No
(if no) Is Intron-A being used for intralesional treatment? ☐ Yes ☐ No
(if intralesional) Does your patient have unresectable disease? ☐ Yes ☐ No
(if intralesional) Does your patient have recurrent or metastatic disease? ☐ Yes ☐ No
(if NOT intralesional) Does your patient have metastatic or unresectable disease? ☐ Yes ☐ No
(if not intralesional) Is your patient using Intron-A in combination with platinum-based chemotherapy (such as carboplatin or cisplatin)? ☐ Yes ☐ No

(if yes) Has your patient tried only one other treatment option for this diagnosis before using Intron-A in combination with platinum-based chemotherapy? ☐ Yes ☐ No
(if no) Did your patient have disease progression while on BRAF therapy (such as dabrafenib [Tafinlar], vemurafenib [Zelboraf])? ☐ Yes ☐ No
(if disease progression) Does your patient have performance status (PS) 0-2? ☐ Yes ☐ No
(if meningioma) Does your patient have surgically unresectable recurrent or progressive disease? ☐ Yes ☐ No
(if meningioma) Was your patient previously treated with radiation for this diagnosis? ☐ Yes ☐ No
(if myelofibrosis) Is your patient symptomatic? ☐ Yes ☐ No
(if myelofibrosis) Does your patient have low-risk myelofibrosis? ☐ Yes ☐ No
(if PV) Has your patient had failure to phlebotomy? ☐ Yes ☐ No
(if RCC) Does your patient have relapsed or stage IV (4) disease? ☐ Yes ☐ No
(if RCC) What is the histology of the disease?
☐ non-clear cell ☐ predominantly clear cell ☐ other
(if predominantly clear cell) Is Intron A being given as first-line therapy in combination with Avastin (bevacizumab)? ☐ Yes ☐ No

Additional Pertinent Information: *Please provide clinical support for the use of this drug in your patient (including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently).*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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