MASSACHUSETTS STANDARD FORM FOR HEPATITIS C MEDICATION PRIOR AUTHORIZATION REQUESTS

**Some plans might not accept this form for Medicare or Medicaid requests.*

A. Destination	
Health Plan or Prescription Plan Name:	
Health Plan Phone:	Health Plan Fax:

B. Patient Information		
Patient Name:	DOB:	Gender: ☐ Male ☐ Female ☐ Other: _____
Member ID #:		

C. Prescriber Information	
Prescribing Clinician:	Phone #:
Specialty:	Secure Fax #:
NPI #:	DEA #:
Prescriber Point of Contact Name (POC) (if different than prescriber):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
Prescribing Clinician or Authorized Representative Signature:	
Date:	

D. Medication Information

Check if Expedited Review/Urgent Request:
☐ (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)

☐ Daklinza ☐ Epclusa ☐ Harvoni ☐ Olysio ☐ Ribavirin Generic ☐ Ribavirin Branded
☐ Sovaldi ☐ Technivie ☐ Viekira Pak ☐ Viekira XR ☐ Zepatier ☐ Other _____

Requested Duration of Treatment: _____ weeks

Type of Therapy: ☐ Initial ☐ Continuation — weeks remaining: _____

Anticipated or actual start date:

Is the medication prescribed by, or in consultation with, a gastroenterologist, infectious disease specialist, or hepatologist? ☐ Yes ☐ No

For Zepatier only: Has there been confirmation that the patient does not have a genotype 1a with a baseline NS5A polymorphism?
☐ Yes ☐ No ☐ Unknown

For Ribavirin only: Does the patient require a dosage form other than generic ribavirin 200 mg capsules or tablets? ☐ Yes ☐ No
If yes, please specify the following:

Dosage form requested: _____

Clinical reason for use: _____

Are any of the following statements true?

☐ Patient is pregnant or plans to become pregnant within 6 months of completing treatment

☐ Patient is male with a female partner who is pregnant or plans to become pregnant within 6 months of completing treatment

☐ Patient has contraindications or intolerance to Ribavirin

(continued on next page)

E. Patient Clinical Information

Please refer to plan-specific criteria for details related to required information.

Diagnosis: ☐ B18.2 Hepatitis C (chronic) ☐ Other: _____

HCV Genotype: ☐ 1 ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

Stage of Hepatic Fibrosis: ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4

If F 4: ☐ Compensated ☐ Decompensated

Check all methods of assessment that apply and include result:

Method	Result
☐ Liver biopsy	See above
☐ Transient elastography (FibroScan)	_____ kPa
☐ Shear wave elastography	_____ kPa
☐ MRE	_____ kPa
☐ FibroSure (FibroTest)	_____
☐ Echosens Fibrometer	_____
☐ Fibrospect	_____
☐ APRI	_____
☐ Fib-4	_____
☐ Hepascore	_____
☐ Other: _____	_____

Does the patient have HIV coinfection? ☐ Yes ☐ No ☐ Unknown

Is the patient status post liver transplant? ☐ Yes ☐ No

Confirm the patient's GFR range: ☐ 0–14 ☐ 15–29 ☐ 30 or greater *(Please specifiy.)* _____

HCV RNA levels:

Baseline (most recent): _____ IU/mL Date of lab work: _____

Week 8 of treatment (if continuation request): _____ IU/mL Date of lab work: _____

Previous Treatments

Has the patient been previously treated for Hepatitis C and failed treatment? ☐ Yes ☐ No

Adverse Reaction? ☐ Yes ☐ No

Drug Name	Date of treatment (MM/YY)	Response to treatment
		☐ Relapsed ☐ Partial response ☐ Null response (<2 log reduction in HCV RNA at Week 12) ☐ Did not complete ☐ Briefly describe details: _____
		☐ Relapsed ☐ Partial response ☐ Null response (<2 log reduction in HCV RNA at Week 12) ☐ Did not complete ☐ Briefly describe details: _____
		☐ Relapsed ☐ Partial response ☐ Null response (<2 log reduction in HCV RNA at Week 12) ☐ Did not complete ☐ Briefly describe details: _____

Additional information pertinent to this request:

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.