Reset Form Print Form

Prior Authorization Form
Hepatitis C Agents

Fax this form to: 1-800-424-3260

A fax cover sheet is not required.

Instructions: Please fill out all applicable sections on all pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the prior authorization). **Information contained in this form is Protected Health Information under HIPAA**.

☐ **NON-URGENT** ☐ **EXIGENT CIRCUMSTANCES**

MEMBER INFORMATION

Member's Last Name:

Member's First Name:

Member's Identification Number:

Date of Birth: ___ – ___ – ____

PRESCRIBER INFORMATION

Prescriber's Last Name:

Prescriber's First Name:

National Provider Identifier (NPI) Number:

DEA Number:

Office Phone Number: ___ – ___ – ____

Office Fax Number: ___ – ___ – ____

CLINICAL CRITERIA

1. What medication is being requested? _____
2. What is the diagnosis for which this drug is being requested?
   - ☐ Chronic hepatitis C, genotype 1 **Note if 1a or 1b:** _____
   - ☐ Chronic hepatitis C, genotype 2
   - ☐ Chronic hepatitis C, genotype 3
   - ☐ Chronic hepatitis C, genotype 4
   - ☐ Chronic hepatitis C, genotype 5
   - ☐ Chronic hepatitis C, genotype 6
3. What is the duration of therapy?
   ☐ 8 weeks ☐ 12 weeks ☐ 16 weeks ☐ 24 weeks ☐ 48 weeks ☐ Other: _____

(Form continued on next page.)

Member's Last Name:

Member's First Name:

4. What is the specialty of the prescribing physician?
   - ☐ Gastroenterologist
   - ☐ Hepatologist
   - ☐ Infectious disease specialist
   - ☐ Other: _____
5. What is the member's current weight? _____
6. Does the member have cirrhosis?
   ☐ Yes ☐ No
7. Does the member have compensated cirrhosis, defined as Child-Pugh score A?
   ☐ Yes ☐ No
8. Does the member have decompensated cirrhosis, defined as Child-Pugh score B or C?
   ☐ Yes ☐ No
9. Does the member have a diagnosis of hepatocellular carcinoma awaiting liver transplant?
   ☐ Yes ☐ No
10. Is the member post liver transplant?
    ☐ Yes ☐ No
11. Is the member post kidney transplant?
    ☐ Yes ☐ No
12. Is the member's creatinine clearance greater than 30 mL/minute?
    ☐ Yes ☐ No
13. Does the member have severe renal impairment or end-stage renal disease?
    ☐ Yes ☐ No
14. Does the member have human immunodeficiency virus (HIV) co-infection?
    ☐ Yes ☐ No
15. Will the member use ribavirin in combination with the requested medication?
    ☐ Yes ☐ No
16. Will the member use peginterferon alfa in combination with the requested medication?
    ☐ Yes ☐ No
17. Will the member use any other hepatitis C agent with the requested agent?
    ☐ Yes ☐ No

    List other hepatitis C agents: _____
18. Which of the following best describes the member prior to this course of treatment for hepatitis C?
    ☐ Treatment-naïve ☐ Treatment-experienced

    If **Treatment-experienced**, please list **ALL** previous hepatitis C regimens this member has received:

    _____

(Form continued on next page.)

 MHID: MRXCOM04_01

Member's Last Name:

Member's First Name:

19. Has the member been evaluated for potential clinically significant drug interactions that will affect the outcome of their therapy?
    ☐ Yes ☐ No

    List any interacting medications: _____

Note: It is recommended that the member be evaluated for current history of substance and/or alcohol abuse with validated screening instruments such as Alcohol Use Disorders Identification Test (AUDIT C) or CAGE alcohol screen, or NIDA's drug screening tool. If the member has a recent prior history of substance or alcohol abuse within the past 6 months, it is recommended to have the member participate (if not already completed) in a recovery program, receive substance or alcohol abuse counseling services, or see an addiction specialist as part of HCV treatment.

20. Does the member have a history, within the past 6 months, of illicit substance or alcohol abuse?
    ☐ Yes ☐ No
21. Has the member been free of substance abuse for the past 6 months?
    ☐ Yes ☐ No
22. Has the member been free of alcohol abuse for the past 6 months?
    ☐ Yes ☐ No
23. For females: Is the member pregnant?
    ☐ Yes ☐ No
24. Has the member been screened for hepatitis B? Please document the member's hepatitis B surface antibody (anti-HBs) surface antigen (HBsAg), and core antibody (anti-HBc) results.
    ☐ Yes ☐ No
25. Has the member received the hepatitis B vaccine series?
    ☐ Yes ☐ No
27. What is the member's current HCV RNA? _____

For Zepatier® (in addition to above):

1. What are the member's baseline hepatic laboratory testing results?

_____

(Form continued on next page.)

Member's Last Name:

Member's First Name:

Is there any other information pertinent to this PA request?

☐ **Attachments**

Note: If approved, compliance with therapy is required. Authorizations will be terminated for members who are noncompliant with therapy.

_____ _____

Prescriber Signature (Required) ***Date***

(By signature, the Physician confirms the above information is accurate and verifiable by patient records.)

Fax this form to: 1-800-424-3260

Mail requests to:
Magellan Rx Management Prior Authorization Program
c/o Magellan Health, Inc.
4801 E. Washington Street
Phoenix, AZ 85034
Phone: 1-800-424-3312

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