Wellpoint

Hepatitis C Therapy Prior Authorization Form

Incomplete forms will be returned

Fax this form to 844-490-4871

Attach copies of the patient's medical history summary, lab, and genetic test reports.

Please review our clinical criteria before submitting this form.

Patient information

Recipient: ______________________________ MA#: ______________________________

Date of birth: _______/_______/_______ Phone #: ______ - _______ - _______ Body weight: _______ kg

Treatment

☐ ______________________: Take ________daily for _______ weeks

☐ ______________________: Take ________daily for _______ weeks

☐ ______________________: Take ________daily for _______ weeks

Adherence with prescribed therapy is a condition for payment of therapy for up to the allowed timeframe for each HCV genotype.

Has a treatment plan been developed and discussed with patient? ☐ No ☐ Yes

Diagnosis

☐ Acute Hep C ☐ Chronic Hep C (Hep C present for ≥ 6 months) as established by **(Please select one.)**

- ☐ Lab testing such as an HCV antibody or HCV RNA test completed 6 months apart
- ☐ HCV diagnosis documented in prescribers note from the past office visit(s)
- ☐ Exposure risk history documented in prescribers notes from the past office visit(s)

☐ Liver transplant recipient: Genotype of pre-transplant liver: ______________________

Genotype of post-transplant liver: ______________________

☐ Other: ____

What is the patient's HCV genotype and subtype? ______________________

Has a liver biopsy been performed? ☐ No ☐ Yes; Test date: _______/_______/_______

Has a fibrosis test been performed: ☐ No

☐ Yes; Test used: ____________; Test date: _______/_______/_______

Metavir grade: _______; Metavir stage: _______

What best describes this patient's liver disease? (Check all that apply.):

☐ No cirrhosis ☐ Compensated cirrhosis ☐ Decompensated liver disease

Please provide a copy of the results of the biopsy, genotype, and any other fibrosis tests for this patient.

Hepatitis C treatment history

Has this patient been treated for Hepatitis C in the past: ☐ Treatment naive ☐ Treatment experienced

If treatment experienced, what was the outcome of the previous treatments:

☐ Relapsed ☐ Partial responder ☐ Non-responder ☐ Toxicities ☐ Reinfection

Please indicate what prior regimen(s) the patient has been treated with:

HCV regimen	Treatment duration/ dates	Treatment Outcome
		☐ Relapsed ☐ Partial responder ☐ Non-responder ☐Toxicities ☐ Reinfection ☐ Other:
		☐ Relapsed ☐ Partial responder ☐ Non-Responder ☐ Toxicities ☐ Reinfection ☐ Other:

Laboratory results

Baseline HCV RNA level (up to and including 180* days prior to treatment): ______________________________

Date: _______/_______/_______

*Unless the patient is cirrhotic then the baseline lab values must be within 90 days of prior authorization request

For cirrhotic patient, please attach total bilirubin, albumin, and INR.

If a regimen is prescribed containing ribavirin, please attach hemoglobin, hematocrit, and platelet count.

Medical history

Is the patient co-infected with HIV? ☐ No ☐ Yes; If yes, state the patient's HIV viral load. ______________
Date drawn: ______________________________________

Is the patient co-infected with HBV? ☐ No ☐ Yes; If yes, state the patient's HBV viral load. ____________
Date drawn: ______________________________________

Is the patient co-infected with other viral infection? ____

Has patient had a solid organ transplant? ☐ No ☐Yes; If yes, specify what type of transplant: ___________
Date of transplant: _______/_______/_______

If the patient's Medicaid eligibility changes during therapy and the patient is no longer eligible for Medicaid prescription drug assistance, is the physician prepared to enroll the patient in other patient assistant drug programs to complete therapy? ☐ Yes ☐ No

Contact person at your office: (name): ________________________Telephone #: _____________________

I certify that the benefits of the treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

Prescriber's signature ____

Prescriber's name ____ Date ______________

Telephone# (_____) – ___________- ______________ Fax# (______) - ___________ - ______________

Practice specialty: ____

Address: ____