BOSTON MEDICAL CENTER HEALTHNet PLAN

ENVISIONRx

PRIOR AUTHORIZATION REQUEST FORM

BMCHP 9.123 Hepatitis C
Harvoni, Infergen, Olysio, Pegasys, Peg-Intron, Rebetol, Sovaldi, Viekera, Viekera XR, Daklinza, Technivie, Epclusa, Zepatier
Version 19.0
Effective 7/17/17

Phone: 888-566-0008 **Fax back to: 866-741-8136**

EnvisonRx Options manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is the request for initial or continuing therapy? If continuing therapy, include the initial treatment start date.

☐ Initial
☐ Continuing (Start date MM/YY): Current treatment stage in weeks:

Q2. Please provide the patient's diagnosis and viral genotype, below:

☐ Hepatitis C, Genotype 1
☐ Hepatitis C, Genotype 2
☐ Hepatitis C, Genotype 3
☐ Hepatitis C, Genotype 4
☐ Hepatitis C, Genotype 5
☐ Hepatitis C, Genotype 6
☐ None of the above

Q3. If the patient has none of the above please list the diagnosis:

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Q4. Is the patient treatment naïve or has the patient had prior treatment?

- ☐ Naive
- ☐ Treatment Experienced

Q5. Please indicate regimen being requested.

- ☐ Harvoni 90 mg/400 mg once daily
- ☐ Harvoni/RBV
- ☐ Sovaldi/Olysio
- ☐ Sovaldi/Daklinza
- ☐ Sovaldi/RBV
- ☐ Olysio/PEG/RBV
- ☐ Viekira Pak/RBV
- ☐ Viekira XR
- ☐ Daklinza
- ☐ Daklinza/Sovaldi/RBV
- ☐ Technivie
- ☐ Zepatier
- ☐ Zepatier/RBV
- ☐ Epclusa
- ☐ Epclusa/RBV
- ☐ Pegasys
- ☐ Pegasys or Pegintron / RBV
- ☐ Other

Q6. If the therapy is OTHER, please list therapy requested

Q7. Please indicate the liver disease stage:

- ☐ Early Stage (e.g. Metavir F0 - F2)
- ☐ Advanced Stage (e.g Metavir F3)

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☐ Cirrhosis (e.g. Metavir F4)

Q8. Duration of therapy being requested:

Q9. Was the baseline viral load (HCV RNA) taken within the last six months?

☐ Yes ☐ No

Q10. Please input the viral load and corresponding date of the viral load.

Q11. Have medical records and results of diagnostic tests assessing hepatic fibrosis including tests supporting liver disease staging been provided?

☐ Yes ☐ No

Q12. Please indicate the patient's response to previous Hepatitis C (HCV) treatment (select all that apply), specify the drug name(s), and if experienced by the patient, describe the intolerance/inadequate response to therapy.

- ☐ Patient is treatment naive
- ☐ Incivek/PEG/RBV
- ☐ Harvoni
- ☐ Harvoni/RBV
- ☐ Viekira Pak/RBV
- ☐ Victrelis/PEG/RBV
- ☐ Sovaldi/Daklinza
- ☐ Sovaldi/RBV
- ☐ Sovaldi/Olysio
- ☐ Sovaldi/PEG/RBV
- ☐ Olysio/PEG/RBV
- ☐ Viekira Pak
- ☐ Technivie
- ☐ PEG/RBV

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Q13. Is the patient considered interferon ineligible?
☐ Yes ☐ No

Q14. If yes, please indicate why the member is interferon ineligible and provide supporting documentation, such as platelet count, etc.

Q15. Is the patient considered ineligible for Daklinza or Harvoni or Sovaldi?
☐ Yes ☐ No

Q16. If yes, please indicate why the member is ineligible for Daklinza or Harvoni or Sovaldi.

Q17. For OLYSIO, did the patient test positive for the NS3 Q80K polymorphism? (please provide lab results)
☐ Yes ☐ No

Q18. For EPCLUSA, what are the results of the NS5A Y93H resistance-associated polymorphism?
☐ Present ☐ Absent

Q19. If requesting brand-name ribavirin, has the patient tried and failed generic ribavirin due to poor compliance?
☐ Yes ☐ No

Q20. If yes, please specify the clinical condition.

Q21. Does the member have any drug-drug interactions with the requested regimen?
☐ Yes ☐ No

Q22. If yes, has the drug-drug interaction been addressed?
☐ Yes ☐ No

Q23. CONTINUATION OF THERAPY: Select all that apply (Please submit office notes verifying member's adherence to the treatment regimen)
☐ Member has been adherent to medication.

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☐ Member has been adherent to office visits and lab work appointments
☐ Member has actively participated in an adherence monitoring program provided by either the Plan's preferred specialty pharmacy or that offered by the prescriber.

Q24. Is the patient's viral load detectable at week 4 of treatment and has it increased by greater than 10 fold upon repeat testing at week 6?

☐ Yes ☐ No

Q25. Treatment will be discontinued if viral load is detectable at week 4 of treatment AND has increased by greater than 10-fold (>1 logR10R IU/mL) on repeat testing at week 6 (or thereafter).

☐ Yes ☐ No

Prescriber Signature

Date