



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Epclusa®

Phone: 215-991-4300

Fax back to: 866-240-3712

Health Partners Plans 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 (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Form with two columns: Patient Name and Prescriber Name. Fields include HPP Member Number, Date of Birth, Address, City, State ZIP, Patient Primary Phone, Line of Business (Medicaid, CHIP), Fax, Office Contact, NPI, Promise ID, Prescriber PA PROMISe ID, Address, City, State ZIP, and Specialty/facility name (if applicable).

Expedited/Urgent

Drug Name:

Strength:

Directions / SIG:

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is the patient over the age of 18?

Yes No

Q2. Does the patient have a short life expectancy that cannot be remediated by treating HCV, by transplantation, or by other directed therapy?

Yes No

Q3. What is the patient's treatment history? Must select at least one of the following AND attach chart notes.

- Treatment-naïve
Treatment-experienced (PegIFN/RBV)
Treatment-experienced (PegIFN/RBV/protease inhibitor)
Treatment-experienced (NS5B inhibitor)
Treatment-experienced (NS5A inhibitor)
Other (please specify)

Q4. If the patient had previous HCV treatment what was the treatment outcome? Must select at least one of the following AND attach chart notes.

- Did not complete treatment due to non-compliance with medications and/or HCV therapy management
Did not complete treatment due to side effects and/or hospitalization
Completed treatment and achieved sustained virologic response (SVR)
Partial responder (PegIFN/RBV)
Null responder (PegIFN/RBV)
Prior-Relapser (PegIFN/RBV)
Protease inhibitor failure
NS5B inhibitor failure



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- NS5A inhibitor failure
Other (please specify)

Q5. Has the provider addressed the cause of non-compliance with previous HCV therapy and provided a new treatment plan to correct or address treatment adherence?

- Yes No

Q6. Has the provider submitted a detectable quantitative HCV RNA that was tested within the past 12 weeks? (Labs must be attached)

- Yes No

Q7. What is the patient's genotype? Labs within the past 12 weeks must be attached. Please select at least one of the following:

- 1
2
3
4
5
6

Q8. Does the provider submit the following laboratory tests (done within the past 12 weeks)? (Labs must be attached) A. Complete blood count (CBC) B. International normalized ratio (INR) C. Hepatic function panel (albumin, total and direct bilirubin, alanine aminotransferase, aspartate aminotransferase, and alkaline phosphatase levels) D. Calculated glomerular filtration rate (GFR) E. Fibrosis score/ Metavir stage F. Hepatitis B screening (sAb/sAg and cAb/cAg) G. HIV screening (HIV Ag/Ab)

- Yes No

Q9. Does the patient have a documented completion of Hepatitis B immunization series? (Documentation must be attached)

- Yes No

Q10. Does the patient test positive for hepatitis BsAg or cAb or cAg? (Labs must be attached)

- Yes No

Q11. Does the patient have a detectable quantitative HBV DNA? (Labs must be attached)

- Yes No

Q12. Will the patient be treated for Hepatitis B? (Treatment plan must be attached)

- Yes No

Q13. Does the patient test negative for hepatitis BsAb? (Labs must be attached)

- Yes No

Q14. Is the patient being vaccinated against Hepatitis B? (Documentation must be attached)

- Yes No

Q15. Has the patient have a confirmed positive HIV-1/HIV-2 differentiation immunoassay? (Labs must be attached)

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Form containing 13 questions (Q16-Q28) with Yes/No checkboxes regarding patient treatment, medical records, and drug interactions.



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Q29. Is the patient willing to be treated and conform to treatment requirements (such as commitment to adherence with hepatitis C treatment course, referral to disease case management, hepatitis C educational/counseling and monitoring program including sustained virologic response (SVR) tracking and reporting)?

Yes No

Q30. Does the patient have medication adherence issues in general (such as non-adherence to medications used to treat other existing or comorbid conditions)?

Yes No

Q31. Is the patient currently treated with the drugs containing sofosbuvir, or combination of drugs containing any other direct-acting antiviral (DAA)?

Yes No

Q32. Is the patient being treated with both Epclusa and RBV? Please select at least one of the following:

Yes
No
No, patient is RBV ineligible

Q33. Does the patient have a hemoglobin level of less than 10 g/dL?

Yes No

Q34. Does the patient have a CrCl of >50 mL/min?

Yes No

Q35. Does the patient have a CrCl between 30-50 mL/min?

Yes No

Q36. Has the RBV dose adjusted by alternating 200 mg and 400 mg every other day?

Yes No

Q37. If female, is she pregnant or planning to become pregnant?

Yes No

Q38. If male, is he with a female partner that is pregnant or planning to become pregnant?

Yes No

Q39. Will the patient use two or more forms of contraception?

Yes No

Q40. Will the patient (if female) or patient's partner (if female) have monthly pregnancy tests during therapy?

Yes No

Q41. Requested duration:

12 weeks 24 weeks Other:

Q42. Additional Information:

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Patient Name:

Prescriber Name:

Prescriber Signature

Date

Updated 2018