



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Vosevi®

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 fields for Patient Name, HPP Member Number, Date of Birth, Address, City, State ZIP, Patient Primary Phone, Line of Business (Medicaid, CHIP), Prescriber Name, Fax, Phone, Office Contact, NPI, Promise ID, Prescriber PA PROMISe ID, Address, City, State ZIP, Specialty/facility name (if applicable).

Expedited/Urgent checkbox

Drug Name:

Strength:

Days Supply:

Number of Refills:

Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

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 checkbox

No checkbox

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

Yes checkbox

No checkbox

Q3. What is the patient's treatment history? Please select at least one of the following (Documentation must be attached)

- 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? Please select at least one of the following (Documentation must be attached)

- 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
Prior-Relapser (PegIFN/RBV)
Protease inhibitor failure
NS5B inhibitor failure
NS5A inhibitor failure

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Patient Name:

Prescriber Name:

Completed treatment and achieved sustained virologic response (SVR)

Other (please specify)

Partial responder (PegIFN/RBV)

Null responder (PegIFN/RBV)

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? (Documentation must be attached)

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. Baseline RAS testing (for Y93H)
B. Complete blood count (CBC)
C. International normalized ratio (INR)
D. Hepatic function panel (albumin, total and direct bilirubin, alanine aminotransferase, aspartate aminotransferase, and alkaline phosphatase levels)
E. Calculated glomerular filtration rate (GFR)
F. Fibrosis score/ Metavir stage
G. Hepatitis B screening (sAb/sAg and cAb/cAg)
H. HIV screening (HIV Ag/Ab)

Yes

No

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

Yes

No

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

Yes

No

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

Yes

No

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Prescriber Name:

Q12. Does the patient have a treatment plan for hepatitis B consistent with AASLD recommendations? (Documentation must be attached)

Yes checkbox

No checkbox

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

Yes checkbox

No checkbox

Q14. Does the patient have a hepatitis B immunization plan or counseling to receive the hepatitis B immunization series? (Documentation must be attached)

Yes checkbox

No checkbox

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

Yes checkbox

No checkbox

Q16. Is the patient being treated for HIV? (Documentation must be attached)

Yes checkbox

No checkbox

Q17. Has the prescriber submitted a medical record documents the rationale for not being treated?

Yes checkbox

No checkbox

Q18. Does the patient have cirrhosis?

Yes checkbox

No checkbox

Q19. Does the patient have decompensated cirrhosis (CTP class B or C)?

Yes checkbox

No checkbox

Q20. Does the patient have a CrCl or GFR less than 30 mL/min?

Yes checkbox

No checkbox

Q21. Does the patient have any contraindication to sofosbuvir/velpatasvir/voxilaprevir?

Yes checkbox

No checkbox

Q22. Has patient's medication profiles been reviewed and shown any contraindicated drug interactions (Risk X) with sofosbuvir/velpatasvir/voxilaprevir?

Yes checkbox

No checkbox

Q23. Has any plan been made to address the contraindicated drug-drug interactions, such as discontinuation, dose reduction of interacting drugs, counseling patient of the risks associated with the potentially significant drug-drug interaction? (Documentation must be attached)

Yes checkbox

No checkbox

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Patient Name:

Prescriber Name:

Q24. Does the patient have a history of chronic alcohol consumption or dependency?

Yes checkbox

No checkbox

Q25. Does the provider submit documentation of counseling regarding the risks of alcohol consumption and offering referral for substance abuse or behavioral health (BH) treatment program?

Yes checkbox

No checkbox

Q26. Does the patient have a history of substance abuse/dependency or illicit drug use?

Yes checkbox

No checkbox

Q27. Does the provider submit documentation of counseling regarding the risk of illicit drug use and offering referral for substance abuse or behavioral health (BH) treatment program?

Yes checkbox

No checkbox

Q28. Does the patient have a history of mental or psychiatric disorders (such as, suicide, suicidal and homicidal ideation, depression, psychoses, schizophrenia, bipolar disorders, mania, anxiety disorder, relapse of drug addiction/overdose and aggressive behavior)?

Yes checkbox

No checkbox

Q29. Was the patient evaluated or treated by a psychiatrist or behavioral health specialist?

Yes checkbox

No checkbox

Q30. 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 checkbox

No checkbox

Q31. Does the patient have medication adherence issues in general (such as non-adherence to medications used to treat other existing or comorbid conditions)?

Yes checkbox

No checkbox

Q32. Is the patient currently treated with the drugs containing sofosbuvir, or combination of drugs containing any other direct-acting antiviral (DAA)?

Yes checkbox

No checkbox

Q33. Requested Duration:

12 Weeks checkbox

Other: checkbox

Q34. Additional Information:



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Patient Name:

Prescriber Name:

Prescriber Signature

Date

Updated 2018