Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Hepatitis C Agents

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.

Patient Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
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. Does the patient have documentation of detectable quantitative HCV RNA at baseline? Note: The prescriber must submit documentation.

☐ Yes ☐ No

Q2. Is documentation of genotype attached to this request If genotyping is recommended by the AASLD?

☐ Yes ☐ No

Q3. Was the patient previously treated for Hepatitis C?

☐ Yes - Please submit documentation of previous regimen, dates, lab work, and treatment outcome ☐ No

Q4. Is the prescribed drug regimen consistent with FDA-approved labeling or nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q5. Is the requested drug age-appropriate for the patient according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed literature?

☐ Yes ☐ No

Q6. Is the patient's Metavir fibrosis score confirmed by recent noninvasive test such as a blood test or imaging, a Fibroscan, or findings on physical examination?

☐ Yes ☐ No

Q7. Has documentation of the recent noninvasive test such as a blood test or imaging, a Fibroscan, or findings on

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.

Patient Name:	Prescriber Name:

physical examination attached to this request?

☐ Yes ☐ No

Q8. Has the patient had a complete hepatitis B immunization series? Note: The prescriber must submit documentation.

☐ Yes ☐ No

Q9. Is documentation for the complete hepatitis B immunization series attached to this request? [If yes, skip to question 22.]

☐ Yes ☐ No

Q10. Has the patient had Hepatitis B screening (sAb, sAg, and cAb)?

☐ Yes ☐ No

Q11. Is the patient positive for hepatitis B sAg?
[If no, skip to question 19.]

☐ Yes ☐ No

Q12. Has the patient had quantitative HBV DNA results? Note: The prescriber must submit documentation.

☐ Yes ☐ No

Q13. Is documentation for the quantitative HBV DNA results attached to this request?

☐ Yes ☐ No

Q14. Is there detectable HBV DNA? Note: The prescriber must submit documentation.

☐ Yes ☐ No

Q15. Has a treatment plan for hepatitis B consistent with AASLD recommendations been developed for the patient? Note: The prescriber must submit documentation.

☐ Yes ☐ No

Q16. Has documentation for the treatment plan attached to this request?

☐ Yes ☐ No

Q17. Is the patient negative for hepatitis B sAb?

☐ Yes ☐ No

Q18. Has a hepatitis B immunization plan or counseling to receive the hepatitis B immunization series been completed? Note: The prescriber must submit documentation.

☐ Yes ☐ No

Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Hepatitis C Agents

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.

Patient Name:	Prescriber Name:

Q19. Has documentation for the treatment plan and patient counseling attached to this request?

☐ Yes ☐ No

Q20. Has the patient had an HIV screening (HIV Ag/Ab)? Note: The prescriber must submit documentation.

☐ Yes ☐ No

Q21. Has documentation for the HIV screening attached to this request?

☐ Yes ☐ No

Q22. Is the patient HIV-positive confirmed positive by HIV-1/HIV-2 differentiation immunoassay?

☐ Yes ☐ No

Q23. Is the patient being treated for HIV?

☐ Yes ☐ No

Q24. Is there documented rationale for the beneficiary for the patient not being treated? Note: The prescriber must submit documentation.

☐ Yes ☐ No

Q25. Is documented rationale attached to this request?

☐ Yes ☐ No

Q26. Does the patient meet both of the following if resistance-associated substitution (RAS) testing is recommended by the AASLD? A) Has documentation of recommended RAS testing and B) The patient is being prescribed an AASLD recommended drug regimen based on the documented results of a NS5A RAS screening?

☐ Yes ☐ No

Q27. Is documentation supporting the RAS testing been attached to this request?

☐ Yes ☐ No

Q28. Does the patient have a life expectancy of less than 12 months due to non-liver-related comorbid conditions?

☐ Yes ☐ No

Q29. Have all potential drug interactions been addressed by the prescriber (such as discontinuation of the interacting drug, dose reduction of the interacting drug, or counseling of the beneficiary of the risks associated with the use of both medications when they interact)?

☐ Yes ☐ No

Q30. Does the patient have a history of therapeutic failure, contraindication, or intolerance to the preferred Hepatitis C Agents appropriate for the beneficiary's genotype according to peer-reviewed medical literature?

Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Hepatitis C Agents

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.

Patient Name:	Prescriber Name:

☐ Yes	☐ No
Q31. Is the patient currently receiving treatment with the same non-preferred Hepatitis C Agent?	
☐ Yes	☐ No
Q32. Does the patient have a documented commitment to adherence with the planned course of treatment and mutual prescriber and Departmental monitoring?	
☐ Yes	☐ No
Q33. Has documentation supporting the adherence commitment been attached?	
☐ Yes	☐ No
Q34. Additional Information:	

Prescriber Signature _____ Date _____

Updated for 2021