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. Is the beneficiary currently being treated with the requested drug?

☐ Yes ☐ No

Q2. If yes, therapy start date:

Q3. Submit documentation from the medical record:

Baseline quantitative HCV RNA and date of testing

☐ Yes ☐ No

Q4. Submit documentation from the medical record:

Cirrhosis assessment documented by a recent noninvasive test and date of testing.

☐ Yes ☐ No

Q5. Submit documentation from the medical record:

Genotype if one of the following (check the appropriate box for the beneficiary):

☐ The beneficiary is prescribed a non-pangenotypic regimen.
☐ The beneficiary is hepatitis C treatment experienced.
☐ The beneficiary has decompensated cirrhosis.
☐ The beneficiary is treatment-naïve (with cirrhosis) and prescribed sofosbuvir/velpatasvir.

Q6. Submit documentation from the medical record:

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:

RAS (resistance-associated substitutions) testing and date of testing if one of the following (check the appropriate box for the beneficiary):

☐ The beneficiary is genotype 1a and prescribed elbasvir/grazoprevir.
☐ The beneficiary is genotype 1a, treatment-experienced, and prescribed ledipasvir/sofosbuvir.
☐ The beneficiary is genotype 3, treatment-naïve (with cirrhosis) or treatment-experienced (without cirrhosis), and prescribed 12 weeks of sofosbuvir/velpatasvir.

Q7. Submit documentation from the medical record:

Results of HIV (HIV Ag/Ab) screening.

☐ Yes ☐ No

Q8. Submit documentation from the medical record:

For requests for NON-PREFERRED agents, documentation that the beneficiary tried and failed or has a contraindication or intolerance to the preferred Hepatitis C Agents.

☐ Yes ☐ No

Q9. Is the beneficiary hepatitis C treatment naïve?

☐ Yes ☐ No

Q10. If the beneficiary has been treated for hepatitis C, please list the treatment regimen:

Q11. Requested Duration:

☐ 8 weeks
☐ 12 weeks
☐ 16 weeks
☐ Other - _____

Q12. Additional Information:

_____ _____

Prescriber Signature Date

Updated for 2023