

HEPATITIS C AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Hepatitis C Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at: <https://www.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services>.

Office contact name/phone:		Prescriber name:	
LTC facility contact/phone:		State license #:	NPI:
Total # pages:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:
Requested drug #1:	Directions:	Qty:	<input type="checkbox"/> 8 weeks <input type="checkbox"/> 16 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> Other: _____
Requested drug #2:	Directions:	Qty:	<input type="checkbox"/> 8 weeks <input type="checkbox"/> 16 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> Other: _____
Is the beneficiary currently being treated with the requested drug(s)?		<input type="checkbox"/> Yes – Therapy start date: _____ <input type="checkbox"/> No	

SUBMIT DOCUMENTATION from the medical record for all items below.

For requests for NON-PREFERRED Hepatitis C Agents direct-acting antivirals (DAAs):

- Documentation that the beneficiary tried and failed or has a contraindication or intolerance to the preferred Hepatitis C Agents. (See the Preferred Drug List for the list of preferred Hepatitis C Agents at: <https://papdl.com/preferred-drug-list>.)
- Cirrhosis assessment documented by a recent noninvasive test and date of testing.
- 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 sofosbuvir-based, sofosbuvir-velpatasvir-voxilaprevir, or sofosbuvir plus glecaprevir-pibrentasvir treatment-experienced.
 - The beneficiary has decompensated cirrhosis and is prescribed ledipasvir-sofosbuvir.
 - The beneficiary is treatment-naïve (with cirrhosis) and prescribed sofosbuvir-velpatasvir.
- 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.

For requests for THERAPEUTIC DUPLICATION of Hepatitis C Agents direct-acting antivirals (DAAs):

For a beneficiary taking more than 1 Hepatitis C Agents DAA product concomitantly:

- The beneficiary has a medical reason for concomitant use of the requested products that is supported by peer-reviewed medical literature or national treatment guidelines.

For requests for ALL OTHER NON-PREFERRED Hepatitis C Agents (e.g., Pegasys): Diagnosis: _____

- The beneficiary has a history of therapeutic failure of or a contraindication or an intolerance to first line therapies.

ATTESTATION from the prescriber for one of the items below.

Check the appropriate box for the beneficiary.

- The beneficiary is hepatitis C treatment naïve.
- The beneficiary has been treated for hepatitis C with the following treatment regimen: _____

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION 866-240-3712

Prescriber Signature:	Date:
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