KAISER PERMANENTE®

Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Hepatitis C Treatment Therapy Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of HCV Antivirals for Treatment of Hepatitis C**.** Please complete and fax this form back to Kaiser Permanente within 24 hours at fax: 1-866-331-2104. If you have any questions or concerns please call 1-866-331-2103. **Request will not be considered unless form is completely filled out. KP-MAS Formulary can be found at: https://clm.kp.org/pkc/mas/operations/medicaid/HepC-PA-Form.pdf**

1- Patient Information

Patient Name: _____ MA#: _____ Kaiser Medical ID#: _____

Date of Birth: _____ Body Weight: _____ kg Phone #: _____

2- Provider information

Does the prescriber have knowledge and experience in the treatment of Hepatitis C as approved by KPMAS (GI; ID; Hepatology; HepC)? □ No □ Yes

Provider Name: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Please check the box that applies:

□ Standard Review (72 hours)

□ Expedited Review (24 hours): By checking this box, I certify that applying 72 hours standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Provider Signature_____

3- Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4- Drug Therapy Selection (Include all that apply if more than 1 drug is prescribed)

Drug 1: Name/Strength_____ Quantity Limit: _____Sig: _____

Treatment Length: _____ Start Date: _____

Drug 2: Name/Strength_____ Quantity Limit: _____Sig: _____

Treatment Length: _____ Start Date: _____

Drug 3: Name/Strength_____ Quantity Limit: _____Sig: _____

Treatment Length: _____ Start Date: _____

5- Diagnosis

□ Acute Hep C □ Chronic Hep C □ Hepatocellular Carcinoma

Patient's HCV genotype and subtype: _____

Has a liver biopsy been performed? □ No □ Yes; Test date: _____

Has a fibrosis test been performed: □ No □ Yes; Test used: _____ Test date: _____ Metavir Grade/Stage*: _____

What best describes this patient's liver disease? □ No cirrhosis □ Compensated cirrhosis □ Decompensated liver disease

***Applicable to treatment for liver fibrosis corresponding to Metavir score of ≥ 2,** unless the patient has a viral condition which is known (documented to) result in an accelerated hepatic disease (fibrosis) progression and /or hepatic decompensation than what is normally expected from the course of chronic HCV. If so, please provide details of viral condition: _____
_____
_____

****Please attach copies of patient's medical history, lab and genetic test reports****

6- Treatment Plan (Select all that apply)

Chronic Hepatitis C Genotype: 1, 4, 5, 6	□ Harvoni (Ledipasvir/Sofosbuvir)
Chronic Hepatitis C Genotype: 1, 2, 3, 4 &/or Liver cancer	□ Sovaldi (Sofosbuvir)
Chronic Hepatitis C Genotype 1, 3	□ Daklinza (Daclatasvir)
Chronic Hepatitis C Genotype 1, 4	□ Zepatier (Elbasvir/Grazoprevir)
Chronic Hepatitis C Genotype 1-6	□ Epclusa (Sofosbuvir/Velpatasvir)
Chronic Hepatitis C Genotype 1-6 treatment naïve and experienced	□ Mavyret (Glecaprevir/Pribrentasvir)
Chronic Hepatitis C Genotype 1-6 prior DAA treatment experienced with a NS5A inhibitor or Sofosbuvir	□ Vosevi (Sofosbuvir/Velpatasvir/Voxilaprevir)

Ribavirin _____ mg: Take _____ in the morning and _____ in the afternoon for _____ weeks

PegIFN _____mcg: Inject once weekly for _____ weeks

Adherence with prescribed therapy is a condition for payment for continuation therapy for up to the allowed timeframe for each HCV genotype.

Has a treatment plan been developed and discussed with patient? □ No □ Yes

Does the patient have any history of medication non-adherence? □ No □ Yes: If yes, please explain the details of non-adherence and how will it be addressed: _____

_____

****Drug Therapy must be in accordance to FDA approved indications for the specific genotype****

7- Hepatitis C Treatment History

Has this patient been treated for Hepatitis C in the past? □ Treatment Naive □ Treatment Experienced

If treatment-experienced, what was the outcome of the previous treatments:

□ Relapsed □ Partial Responder □ Non-Responder □ Toxicities

Genotype pre-DAA therapy and Date: _____ Genotype post-DAA therapy and Date: _____

Please indicate what prior regimen(s) the patient has been treated with:

HCV Treatment	Duration	Dates	Outcome	Post-treatment HCV RNA Result and Date
			□ Relapsed □ Partial Responder □ Non-Responder □ Toxicities Other_____	
			□ Relapsed □ Partial Responder □ Non-Responder □ Toxicities Other_____	

8- Laboratory Results

Type of Test		Result	Date
Baseline HCV RNA level **(within 90 days of treatment)**			
Hepatic Panel	Baseline ALT		
	Baseline AST		
CBC	Baseline hemoglobin		
	Baseline hematocrit		
	Baseline platelet		
GFR or SCr (GFR >/ 30Ml/Min is required for approval of Daklinza, Sovaldi, Harvoni, Epclusa, Vosevi)			
Child-Pugh Score (Child-Pugh Status of A required for patients with cirrhosis (stage 4 by Metavir) for Zepatier, Mavyret, Vosevi; Child-Pugh Status of A for compensated cirrhosis for Epclusa; Child-Pugh Status of B and C for decompensated cirrhosis for Epclusa)			
Negative Q80K Polymorphism Sovaldi			
NS5A Polymorphisms Zepatier when applicable			

9- Medical History

History of HIV/HCV co-infection? □ No □ Yes; If yes, HIV viral load: _____ Date drawn: _____
Current antiretroviral regimen:_____

History of HBV infection? □ No □ Yes; If yes, HBV status: _____ Hep B viral load: _____ Date drawn: _____
Current antiretroviral regimen: _____

History of solid organ transplant? □ No □ Yes; Specify type of transplant _____Date of Transplant: _____

History of depression or mood disorder? □ No □ Yes; If yes, is patient stable on current medication? □ No □ Yes

10- Substance Use History

Presence of active diagnosis of substance use disorder? □ No □ Yes

If yes, is patient actively engaged in treatment? □Yes □ No

If no, please indicate whether an adherence assessment has been done to assure successful treatment completion:

□Yes □ No, please provide detail assessment plan: _____

_____

11- Provider Sign off

If the patient's Medicaid eligibility changes during therapy and the patient is no longer eligible for Medicaid prescription drug assistance, is the physician prepared to enroll the patient in other patient assistant drug programs to complete therapy? □No □ Yes

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**