Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Hepatitis C Agents Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorization: 1 year

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Hepatitis C Agents.** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: http://pithelp.appl.kp.org/MAS/formulary.html**

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

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/Formulation: _____
Sig: _____ Treatment Length: _____ Start Date: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____ Treatment Length: _____ Start Date: _____

Drug 3: Name/Strength/Formulation: _____
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

6 – Medical and Substance Use History

Patient is ≥ 18 years old □ No □ Yes

History of HIV/HCV co-infection? □ No □ Yes; If yes, state the patient's HIV viral load: _____ Date drawn: _____

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

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: _____
_____

7 – 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	□ Olysio (Simeprevir)
Chronic Hepatitis C Genotype 1a or 1b	□ Viekira Pak □ Viekira XR (Ombitasvir/Paritaprevir, Ritonavir/Dasabuvir)
Chronic Hepatitis C Genotype 1, 3	□ Daklinza (Daclatasvir)
Chronic Hepatitis C Genotype 1, 4	□ Zepatier (Elbasvir/Grazoprevir)
Chronic Hepatitis C Genotype 4	□ Technivie (Ombitasvir/Paritaprevir//Ritonavir)
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

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**

8 – 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

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	
			□ Relapsed □ Partial Responder □ Non-Responder □ Toxicities	

9 – Laboratory Results

Type of Test		Result	Date
Baseline HCV RNA level			
Hepatic Panel	Baseline ALT		
	Baseline AST		
CBC	Baseline hemoglobin		
	Baseline hematocrit		
	Baseline platelet		
GFR or SCr (GFR ≥30 mL/min required for Daklinza, Sovaldi, Harvoni, Olysio, Epclusa, Vosevi)			
Child-Pugh Score (Child-Pugh Status of A required for patients with cirrhosis (stage 4 by Metavir) for Zepatier, Viekira Pak, Viekiera XR, Technivie, 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 Olysio and Sovaldi			
NS5A Polymorphisms Zepatier when applicable			

10 – Provider Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration.

_____

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

Provider Signature:	**Date:**