Hepatitis C Medications

Epclusa® (sofosbuvir/velpatasvir), **Harvoni**® (ledipasvir/sofosbuvir),
Mavyret™ (glecaprevir/pibrentasvir), **Sovaldi**® (sofosbuvir),
Viekira Pak®, **Viekira XR**® (ombitasvir/paritaprevir/ritonavir + dasabuvir)
Vosevi™ (sofosbuvir, velpatasvir, voxilaprevir), **Zepatier**® (elbasvir/grazoprevir

Medication Request Form (MRF)
FAX TO: (844) 403-1029
c/o OptumRx

Attn: Prior Authorization Department
P. O. Box 25183, Santa Ana, CA 92799 - Phone: 1-855-258-1561

Instructions:

This form is to be used by participating providers to obtain coverage for the drugs listed above, which require prior authorization. Please complete this form and fax it to **OptumRx** at (844) 403-1029. If you have any questions regarding this process, please contact OptumRx's Customer Service at 1-855-258-1561. Questions about the clinical criteria used to make this determination may be discussed by contacting the Clinical Pharmacy Services Department.

***** ONLY SIGNED AND COMPLETED FORMS CAN BE PROCESSED *****

Member/Provider Information:

HPHC Member's Name:	**Provider's Name:**
HPHC Member's HPHC ID #:	**Provider's Specialty:**
HPHC Member's DOB (mm-dd-yy):	**DEA #:** ________________________
HPHC Member's Weight: _______(kg)	**HPHC-Affiliated Physician?** ☐ **YES** ☐ **NO**
Pharmacy used by Member:	**Provider's Telephone Number/Contact Name:**
Pharmacy (Area Code) Telephone Number:	**Provider's (Area Code) Fax Number:**

Clinical Information

Drug(s) Requested:

Harvard Pilgrim Preferred Therapies:

☐ **Epclusa (sofosbuvir/velpatasvir)** ☐ **Harvoni (ledipasvir/sofosbuvir)**
☐ **Mavyret (glecaprevir/pibrentasvir)** ☐ **Vosevi (sofosbuvir/velpatasvir/voxilaprevir)**

Harvard Pilgrim Non-Preferred Therapies:

☐ **ledipasvir/sofosbuvir** ☐ **Sovaldi (sofosbuvir)**
☐ **sofosbuvir/velpatasvir** ☐ **Viekira Pak (ombitasvir/paritaprevir/ritonavir/dasabuvir)**
☐ **Viekira XR (dasabuvir/ombitasvir/paritaprevir/ritonavir extended-release)**
☐ **Zepatier (elbasvir/grazoprevir)** ☐ **Other:**_____________________

If the request is not for one of Harvard Pilgrim's preferred therapies, is there clinical rationale for not using the preferred therapy? ☐ Yes ☐ No
If yes, rationale: ____

Dose and Quantity:

Date Requested:	**Length of Treatment:**__________weeks

Is the request for additional weeks of treatment beyond what was originally approved? ☐ Yes ☐ No
If yes, did the patient receive a complete course of therapy? ☐ Yes ☐ No

Documentation of Medical Necessity: (please check all that apply)

1. Does the patient have chronic hepatitis C (i.e. diagnosis for a minimum of 6 months)? ☐ Yes ☐ No
2. Is the requested medication being prescribed by (or in consultation with) a hepatologist, gastroenterologist, infectious disease specialist, or HIV specialist certified through the American Academy of HIV Medicine? ☐ Yes ☐ No
3. Has an invasive or non-invasive test been done to stage the patient's liver disease? ☐ Yes ☐ No
   If yes, please indicate the testing method and result AND provide documentation of result.
   ☐ METAVIR score: ___________ ☐ Fibroscan score:_______________ ☐ FibroSURE score:________ ☐ APRI score: ____________
   ☐ Radiological imaging: _________ ☐ Other:_____________________________ Date of test:________________
4. Please indicate hepatitis C genotype: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
   If genotype 1, please select subtype: ☐ 1a ☐ 1b ☐ mixed ☐ unknown
5. Does the patient have cirrhosis? ☐ Yes ☐ No
   If yes, is it compensated or decompensated cirrhosis? ☐ compensated ☐ decompensated
6. What is the patient's pre-treatment HCV RNA level?
   Date of test: ________________ Result: _______________ Please provide documentation of result.

Note: this form continues onto a second page; incomplete forms cannot be processed

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7. Has the patient been treated previously for Hepatitis C? ☐ Yes (treatment-experienced) ☐ No (treatment-naïve)
   If yes, please list previous treatment regimens [please include concurrent use of PEG-IFN (interferon) or RBV (ribavirin)].
   Medications: ____ Dates: ___________________________
   Medications: ____ Dates: ___________________________
8. Will the requested medication be used in combination with ribavirin? ☐ Yes ☐ No
9. Does the patient have severe renal disease? ☐ Yes ☐ No
   If yes, please provide details: ESRD Creatinine clearance (CrCl): __________ mL/min
10. Does the patient have a history of a liver transplant? ☐ Yes ☐ No
11. Is the requested medication to be used in combination with another HCV direct acting antiviral agent? ☐ Yes ☐ No
    If yes, please provide clinical rationale: ____

For patients with HIV co-infection

1. Is the patient co-infected with HIV? ☐ Yes ☐ No
2. Is the patient's antiretroviral regimen being managed by a physician specializing in the treatment of HIV? ☐ Yes ☐ No

For Zepatier (elbasvir/grazoprevir)

1. If genotype 1a or 1 with mixed or unknown subtypes, has the patient been tested for the presence of virus with NS5A resistance-associate polymorphisms? ☐ Yes ☐ No
   If yes, does the patient have NS5A polymorphisms at baseline? ☐ Yes ☐ No

Additional information pertinent to this request: ____
____
____
____

<u>Important:</u> In addition to this Medication Request Form, please include <u>documentation</u> of a confirmed diagnosis of chronic Hepatitis C (requested in #1), genotype (requested in #4) and result of the HCV RNA viral load (requested in #6).

By signing this form, I attest (i) the information is true and accurate to the best of my knowledge and (ii) that the documentation supporting the information provided on this form is recorded in the patient's medical records.

Prescribing Clinician or Authorized Representative Signature: ______________________________ **Date:**______________