Pre-Authorization Form for Hepatitis C Adjuvant therapy

Kindly fill in all the requested information given below. This is a mandatory step to proceed further. Failure to provide information relevant to approval will delay the processing of the applicant's request. The provider will be contacted in case further clarifications are required.

GENERAL INFORMATION

- Member Card #: _____
- Member Age: _____

PROVIDER INFORMATION

- Provider's Name: _____
- Ordering Clinician specialty: _____

CLINICAL CRITERIA

Diagnosis (check all applicable):

- ☐ Chronic Hepatitis C Infection
- ☐ Treatment Naïve
- ☐ Treatment experienced.
- ☐ Compensated Cirrhosis
- ☐ Decompensated Cirrhosis
- ☐ HIV Co-infection
- ☐ Hepatocellular Carcinoma awaiting liver transplantation.
- ☐ Post Liver Transplant

REQUESTED THERAPY

Please Check if any:

- ☐ Olysio (Simeprevir)
- ☐ Victrelis (Boceprevir)
- ☐ Incivo (Telaprevir)
- ☐ Harvoni (ledipasvir/sofosbuvir)
- ☐ Sovaldi (sofosbuvir)
- ☐ Viekira Pak (ombitasvir/paritaprevir/ritonavir/dasabuvir)
- ☐ Daklinza (daclatasvir)
- ☐ Exviera (Dasabuvir)
- ☐ VOSEVI (sofosbuvir, velpatasvir, and voxilaprevir)

Other combination regimen (please specify): _____

Requested therapy duration:

Estimated total length of therapy:

LABORATORY REPORTS AND MEDICAL REPORTS RESULTS

HCV lab confirmed Hepatitis C genotype / subtype:

- ☐ **1a** _____
- ☐ **1b** _____
- ☐ **2** _____
- ☐ **3** _____
- ☐ **4** _____
- ☐ **5** _____
- ☐ **6** _____

HCV RNA lab confirmed quantitative viral load (within past 6 months): Baseline RNA level: _____ IU/ML

Date of Lab___/___/___

PREVIOUS HCV THERAPY

Has member been on previous HCV monotherapy or combination therapy?

- ☐ YES*
- ☐ NO

*If yes, please fill below all regimens and course of therapies prescribed to this member by present and previous treating physicians:

A. If treated experienced with other Hepatitis C medications, is compliance/adherence documented verifiable for previous treatment?

- ☐ YES
- ☐ NO

B. HCV Regimens COMPLETED as prescribed:

1. Drug: _____
   Dates of Therapy: _____/_____/_____To: _____/_____/_____
   Weeks Completed: _____

Response to Therapy _____

2. Drug: _____
   Dates of Therapy: _____/_____/_____To: _____/_____/_____
   Weeks Completed: _____

Response to Therapy_____

C. HCV Regimens NOT COMPLETED as prescribed

1. Drug: _____
   Dates of Therapy: _____/_____/_____To: _____/_____/_____
   Weeks Completed: _____

Response to Therapy_____

2. Drug: _____
Dates of Therapy: _____/_____ /_____To: _____/_____/_____
Weeks Completed: _____

Response to Therapy_____

* For extra information; please submit additional pages with this request.

PREVIOUS HCV THERAPY

Has member been on previous HCV monotherapy or combination therapy?

☐ YES*

☐ NO

*If yes, please fill below all regimens and course of therapies prescribed to this member by present and previous treating physicians:

A. If treated experienced with other Hepatitis C medications, is compliance/adherence documented verifiable for previous treatment?

☐ YES

☐ NO

B. HCV Regimens COMPLETED as prescribed:

1. Drug: _____
Dates of Therapy: _____/_____/_____To: _____/_____/_____
Weeks Completed: _____

Response to Therapy _____

2. Drug: _____
Dates of Therapy: _____/_____/_____To: _____/_____/_____
Weeks Completed: _____

Response to Therapy_____

C. HCV Regimens NOT COMPLETED as prescribed

1. Drug: _____
Dates of Therapy: _____/_____/_____To: _____/_____/_____
Weeks Completed: _____

Response to Therapy_____

2. Drug: _____
Dates of Therapy: _____/_____ /_____To: _____/_____/_____
Weeks Completed: _____

Response to Therapy_____

* For extra information; please submit additional pages with this request.

LIVER ASSESSMENT
- Child Pugh Score: _____ - Date: _____ /_____ /_____ (must be within 30 days prior of this request) □ Class A (5-6 points) □ Class B (7-9 points) □ Class C (10-15 points)

BLOOD TEST	STATUS	
Liver function tests (LFTs)	□ YES	□ NO
Complete Blood Count (CBC) with white cell differential count	□ YES	□ NO
Haemoglobin (Hgb): _____ g/dL	□ YES	□ NO
Serum Bilirubin, Albumin, and International normalized ratio (INR)	□ YES	□ NO
Serum Creatinine: _____ Date of Test: ___ /___ /___	□ YES	□ NO
Renal impairment (eGFR must be > 30mL/min/1.73m2)	□ YES	□ NO
*If not please submit screening labs (HBsAg, HBsAb and HBcAb)		