UnitedHealthcare Community Plan

Hepatitis C Medications - Minnesota
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Member Information			Prescriber Information		
Member Name:			Provider Name:		
Member ID:			NPI #:	Specialty:	
Date Of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP Code:	Office Street Address:		
Phone:	Allergies:		City:	State:	ZIP Code:

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____
Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____
Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Medication Information

Medication:	**Strength:**
Directions for use:	**Quantity:**

Medication Administered: ☐ Self-Administered ☐ Physician's Office ☐ Other: _____

Clinical Information

What is the patient's diagnosis for the medication being requested? _____

_____

ICD-10 Code(s): _____

Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

What medication(s) does the patient have a history of failure to? *(Please specify ALL medication(s)/strengths tried, directions, length of trial, date(s) of therapy, and reason for discontinuation of each medication)*

What medication(s) does the patient have a contraindication or intolerance to? *(Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)*

Are there any supporting laboratory or test results related to the patient's diagnosis*? (Please specify or provide documentation)*

Additional information that may be important for this review

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS

	Document the patient's genotype: _____
	Document the patient's weight: _____ kg
	Select the patient's liver cirrhosis status: □ No cirrhosis □ Compensated cirrhosis (Child-Pugh A) □ Decompensated cirrhosis (Child-Pugh B or C)
	Duration of treatment: □ 8 weeks □ 12 weeks □ 16 weeks □ 24 weeks □ Other: ____ weeks
□ **Yes** □ **No**	**Is the patient treatment-experienced?**
□ **Yes** □ **No**	**Does the patient have Hepatitis B and/or HIV co-infection?**
□ **Yes** □ **No**	**Has the patient undergone liver transplantation?**
□ **Yes** □ **No**	**Is the patient awaiting liver transplantation?**
□ **Yes** □ **No**	**Is the patient a kidney transplant recipient?**
□ **Yes** □ **No**	**Does the patient have liver cancer?**
□ **Yes** □ **No**	**Does the patient have severe liver disease defined as ONE of the following?** *(If yes, check which applies)* □ APRI (aspartate aminotransferase to platelet ratio index) greater than 1.5 □ FibroSURE greater than 0.49 □ Fibroscan greater than 9.5 kPa (kilopascal) □ FIB-4 (Fibrosis-4) greater than 3.25 □ MR (magnetic resonance) Elastography greater than 6 kPa □ Fibrospect greater than 42 □ Liver Biopsy greater than F3
□ **Yes** □ **No**	**Is the requested medication prescribed by one of the following?** *(If yes, check which applies)* □ Gastroenterologist □ Hepatologist □ Infectious disease specialist □ Nurse practitioner or physician assistant working with one of the following specialists: Gastroenterologist, hepatologist, infectious disease specialist □ Primary care provider
□ **Yes** □ **No**	**Does the patient have a substance use disorder or IV (intravenous) drug use?**
□ **Yes** □ **No** □ **Not applicable**	**If yes to the above, does the patient meet any of the following?** *(If yes, check which applies)* □ The prescriber attests that the patient is enrolled in a substance use disorder treatment program □ There is documentation the patient has been counseled about measures to reduce the risk of HCV (hepatitis C virus) transmission to others □ The patient has been offered at least TWO of the following harm reduction services, as described in AASLD/IDSA (American Association for the Study of Liver Diseases/Infectious Diseases Society of America) HCV guidelines: • Condom distribution (for example, written prescription for condoms, clinic receipt of condom purchase for distribution within the past 12 months, etc.) • Access to sterile syringes (for example, written prescription for needles and syringes, copy of educational materials on syringe access and disposal provided to the patient, etc.) • Naloxone training and distribution (for example written prescription for naloxone, copy of current naloxone training protocol etc.) • Medication-assisted treatment options (for example, provider's attestation of methadone program enrollment, prescription for buprenorphine substantiated by pharmacy claims data) □ Provide the reason the patient is not a candidate for ANY of the harm reduction services above: _____ _____

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□ Yes □ No	**Does the prescriber attest that the patient has been screened for evidence of current or prior hepatitis B virus (HBV) infection before starting treatment with direct-acting antivirals?**
□ Yes □ No	**Is there evidence of current or prior HBV infection?**
□ Yes □ No □ Not applicable	**If yes to the above, does the patient meet any of the following?** *(If yes, check which applies)* □ Prescriber has a monitoring plan in place for HBV flare-ups or reactivation during treatment and post-treatment follow up □ There is documentation that the patient has been counseled on the HBV reactivation adverse events management plan AND the risk of HBV reactivation, including serious liver injury and death
□ Yes □ No	**Will the prescriber submit pretreatment detectable HCV RNA (ribonucleic acid) viral load value, measured within 1 year of treatment start date?** *MUST be included with this request*
□ Yes □ No	**Does the provider attest to submit SVR12 (sustained virologic response after 12 weeks) results to the Department via fax at 651-431-7424 or upon request?**
□ Yes □ No	**Are there any clinically significant drug interactions with the patient's existing medications that cannot be mitigated?**
□ Yes □ No	**Is the patient pregnant?**
□ Yes □ No	**Does the patient have severe end organ disease that is not eligible for transplant (such as liver, heart, lung, kidney)?**
□ Yes □ No	**Does the patient have clinically-significant illness or any other major medical disorder that may interfere with the patient's abilities to complete a course of treatment?**
□ Yes □ No	**In the professional judgment of the primary treating clinician, is the patient able to achieve a long term clinical benefit from HCV treatment (this excludes, for example, patients with multisystem organ failure; receiving palliative care or in hospice; significant pulmonary or cardiac disease; and malignancy outside of the liver not meeting oncologic criteria for cure)?**
□ Yes □ No	**Does the patient have decompensated liver disease with CTP (Child-Turcotte-Pugh) greater than 12 or MELD (Model for End Stage Liver Disease) greater than 20?**
□ Yes □ No	**Does the patient have MELD less than or equal to 20 with any of the following?** *(If yes, check which applies)* □ Cardiopulmonary disease that cannot be corrected and is a prohibitive risk for surgery □ Malignancy outside the liver not meeting oncologic criteria for cure □ Hepatocellular carcinoma □ Intrahepatic cholangiocarcinoma □ Hemangiosarcoma
□ Yes □ No	**Does the patient have a contraindication to the requested drug or drug combination?**
□ Yes □ No	**Has the patient previously been treated with a regimen containing any of the following?** *(If yes, check which applies)* □ An NS5A inhibitor without prior treatment with an NS3/4A protease inhibitor □ An NS3/4A protease inhibitor without prior treatment with an NS5A inhibitor □ Interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A protease inhibitor or NS5A inhibitor □ Interferon based regimen □ Peginterferon alfa + ribavirin □ Peginterferon alfa + ribavirin + HCV NS3/4A protease inhibitor □ Sofosbuvir without an NS5A inhibitor □ Other: _____
□ Yes □ No	**Will the requested medication be used in combination with any of the following?** *(If yes, check which applies)* □ Peginterferon alfa □ Ribavirin

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□ Yes □ No	**Is the patient ineligible for any of the following?** *(If yes, check which applies)* □ Interferon □ Ribavirin
□ Yes □ No	**For Harvoni requests:** **Does the patient have pre-treatment HCV RNA less than 6 million IU/mL?**
□ Yes □ No	**For Zepatier requests:** **Does the patient have baseline NS5A polymorphisms?**
NON-PREFERRED MEDICATIONS FOR TREATMENT-NAÏVE PATIENTS	
□ Yes □ No	**Is the patient a candidate for Mavyret?**
□ Yes □ No	**Does the patient have a non-mitigatable drug interaction with the preferred drug?**
□ Yes □ No □ Not applicable	**If yes to the above, has the prescriber conducted and submitted a comprehensive review of the patient's entire drug therapy regimen (such as, all drugs prescribed by all prescribers and dispensed to the patient) clearly identifying the interacting drug(s) at the time of request?**
□ Yes □ No	**Does the patient meet the drug-specific criteria in the appropriate table below?** *Must provide clinical evidence of why medication(s) in the lower tier(s) cannot be used*

Tier Approach to Nonpreferred Drugs for Treatment-Naïve Patients, Genotype 1

Tier	Nonpreferred Drug	PA Criteria Genotype 1
1	Zepatier	
2	Sofosbuvir-velpatasvir	The prescriber must provide compelling clinical evidence of why drug in tier 1 cannot be used.
3	Epclusa	The prescriber must provide compelling clinical evidence of why drug in tier 1 or 2 cannot be used.
4	Lepidasvir-sofosbuvir	The prescriber must provide compelling clinical evidence of why drug in tier 1, 2, or 3 cannot be used.
5	Harvoni tablet	The prescriber must provide compelling clinical evidence of why drug in tier 1, 2, 3, or 4 cannot be used.
6	Harvoni pellet	The prescriber must provide compelling clinical evidence of why drug in tier 1, 2, 3, 4, or 5 cannot be used.
7	Sovaldi tablet	The prescriber must provide compelling clinical evidence of why drug in tier 1, 2, 3, 4, 5, or 6 cannot be used.
8	Viekira Pak	The prescriber must provide compelling clinical evidence of why drug in tier 1, 2, 3, 4, 5, 6, or 7 cannot be used.

Tier Approach to Nonpreferred Drugs for Treatment-Naïve Patients, Genotype 2 or 3

Tier	Nonpreferred Drug	PA Criteria Genotype 2 or 3
1	Sofosbuvir-velpatasvir	
2	Epclusa	The prescriber must provide compelling clinical evidence of why drug in tier 1 cannot be used.
3	Sovaldi tablet	The prescriber must provide compelling clinical evidence of why drug in tier 1 or 2 cannot be used.
4	Sovaldi pellet	The prescriber must provide compelling clinical evidence of why drug in tier 1, 2, or 3 cannot be used.

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Tier Approach to Nonpreferred Drugs for Treatment-Naïve Patients, Genotype 4, 5, or 6

Tier	Nonpreferred Drug	PA Criteria Genotype 4, 5, or 6
1	Sofosbuvir-velpatasvir	
2	Epclusa	The prescriber must provide compelling clinical evidence of why drug in tier 1 cannot be used.
3	Lepidasvir-sofosbuvir	The prescriber must provide compelling clinical evidence of why drug in tier 1 or 2 cannot be used.
4	Harvoni tablet	The prescriber must provide compelling clinical evidence of why drug in tier 1, 2, or 3 cannot be used.
5	Harvoni pellet	The prescriber must provide compelling clinical evidence of why drug in tier 1, 2, 3, or 4 cannot be used.

Provider Signature: _____ **Date:** _____