Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

Hepatitis C Agents Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

PA Requirements for ALL Agents (submission of medical records (e.g., chart notes, laboratory values) required):

Requested treatment duration (in weeks): _____

Does the recipient have a documented diagnosis of chronic hepatitis C? ❑ **Yes** ❑ **No**

HCV Genotype: _____ HCV RNA level (pre-treatment): _____

Is the medication prescribed by or in consultation with a hepatologist, gastroenterologist, infectious disease specialist, or HIV specialist (certified through the American Academy of HIV Medicine)? ❑ **Yes** ❑ **Other:** _____

Is the recipient treatment-naïve? ❑ **Yes** ❑ **No**

If **no,** with which of the following therapeutic agents has the recipient experienced treatment failure (defined as viral relapse, breakthrough while on therapy, or is a non-responder to therapy) in previous treatment regimens:

Direct-acting antivirals: ❑ NS5A inhibitor ❑ NS5B inhibitor ❑ NS3/4A protease inhibitor

Other: ❑ Ribavirin ❑ Peginterferon alfa ❑ Interferon alfa

Please list all previous treatment regimens and dates of use: _____

_____

Recipient's current hepatic status: (select all that apply)

- ❑ Normal
- ❑ Mild hepatic impairment (Child-Pugh Class A, compensated cirrhosis)
- ❑ Moderate hepatic impairment (Child-Pugh Class B, decompensated cirrhosis)
- ❑ Severe hepatic impairment (Child-Pugh Class C, decompensated cirrhosis)
- ❑ Liver transplant recipient

Recipient's hepatic fibrosis level (e.g., METAVIR fibrosis score): _____

Will the recipient receive any other treatment in combination with requested therapy (e.g., ribavirin, peginterferon alfa, another HCV direct acting antiviral)? ❑ **Yes** ❑ **No**

If **yes**, please list concurrent therapy: _____

For pediatric patients only: Recipient's current weight: _____

Drug-Specific Information (required)

Daklinza® (daclatasvir)

Does the recipient have a documented diagnosis of chronic hepatitis C genotype 1 or 3? ❑ **Yes** ❑ **No**

Will the medication be used in combination with Sovaldi ® (sofosbuvir)? ❑ **Yes** ❑ **No**

If the recipient has decompensated cirrhosis or is a liver transplant recipient, will the medication be used in combination with ribavirin?

❑ **Yes** ❑ **No** ❑ **N/A**

Has the recipient experienced treatment failure (defined as viral relapse, breakthrough while on therapy, or is a non-responder to therapy) with a previous HCV NS5A treatment regimen? ❑ **Yes** ❑ **No**

Epclusa® (sofosbuvir/velpatasvir)

Will the recipient receive another HCV direct acting antiviral agent in combination with requested therapy? ❑ **Yes** ❑ **No**

Has the recipient experienced treatment failure (defined as viral relapse, breakthrough while on therapy, or is a non-responder to therapy) with a previous HCV NS5A treatment regimen? ❑ **Yes** ❑ **No**

If the recipient has decompensated cirrhosis or is a liver transplant recipient, will the medication be used in combination with ribavirin?

❑ **Yes** ❑ **No** ❑ **ribavirin ineligible** ❑ **N/A**

Harvoni® (ledipasvir/sofosbuvir)

Does the recipient have a documented diagnosis of chronic hepatitis C genotype 1, 4, 5, or 6? ❑ **Yes** ❑ **No**

Will the recipient receive another HCV direct acting antiviral agent in combination with requested therapy? ❑ **Yes** ❑ **No**

What is the recipient's pre-treatment HCV RNA (Documentation required)? ❑ **< 6 million IU/mL** ❑ **≥ 6 million IU/mL**

Has the recipient experienced treatment failure with a previous regimen that included peginterferon plus ribavirin with or without an NS3/4A protease inhibitor, e.g., Olysio® (simeprevir), Incivek® (telaprevir), Victrelis® (boceprevir)?

❑ **Yes** ❑ **No**

Has the recipient experienced treatment failure with a previous regimen that included Sovaldi®, except in combination with Olysio®?

❑ **Yes** ❑ **No**

Will the medication be used in combination with ribavirin? ❑ **Yes** ❑ **No** ❑ **ribavirin ineligible**

Has the recipient experienced treatment failure (defined as viral relapse, breakthrough while on therapy, or is a non-responder to therapy) with a previous HCV NS5A treatment regimen? ❑ **Yes** ❑ **No**

Mavyret® (glecaprevir/pibrentasvir)

Will the recipient receive another HCV direct acting antiviral agent in combination with requested therapy? ❑ **Yes** ❑ **No**

Has the recipient experienced treatment failure with a previous regimen that included an NS3/4A protease inhibitor, e.g., Olysio® (simeprevir), Incivek® (telaprevir), Victrelis® (boceprevir)? ❑ **Yes** ❑ **No**

Has the recipient experienced treatment failure with a previous regimen that included interferon, peginterferon, ribavirin, and/or Sovaldi® (sofosbuvir)? ❑ **Yes** ❑ **No**

Has the recipient experienced treatment failure (defined as viral relapse, breakthrough while on therapy, or is a non-responder to therapy) with a previous HCV NS5A treatment regimen? ❑ **Yes** ❑ **No**

Olysio® (simeprevir)

Does the recipient have a documented diagnosis of chronic hepatitis C genotype 1a, 1b or 4? ❑ **Yes** ❑ **No**

If the recipient has genotype **1a**, does the recipient have the NS3 Q8K polymorphism? ❑ **Yes** ❑ **No**

Has the recipient experienced treatment failure with a previous regimen that included an NS3/4A protease inhibitor, e.g., Olysio® (simeprevir), Incivek® (telaprevir), Victrelis® (boceprevir)? ❑ **Yes** ❑ **No**

Will the medication be used in combination with peginterferon alfa and ribavirin? ❑ **Yes** ❑ **No**

Will the medication be used in combination with Sovaldi® (sofosbuvir)? ❑ **Yes** ❑ **No**

Sovaldi® (sofosbuvir)

Does the recipient have a documented diagnosis of chronic hepatitis C genotype 1, 2, 3, or 4? ❑ **Yes** ❑ **No**

If the recipient is less than 12 years of age, does the recipient weigh at least 35kg? ❑ **Yes** ❑ **No**

Has the recipient experienced treatment failure with a previous regimen that included Sovaldi®? ❑ **Yes** ❑ **No**

Will the medication be used in combination with both peginterferon alfa and ribavirin? ❑ **Yes** ❑ **No**

Will the medication be used in combination with ribavirin only? ❑ **Yes** ❑ **No**

Will the medication be used in combination with Olysio® (simeprevir)? ❑ **Yes** ❑ **No**

If **yes**, has the recipient experienced treatment failure with a previous regimen that included an NS3/4A protease inhibitor, e.g., Olysio® (simeprevir), Incivek® (telaprevir), Victrelis® (boceprevir)? ❑ **Yes** ❑ **No**

Will the medication be used in combination with Daklinza® (daclatasvir)? ❑ **Yes** ❑ **No**

If **yes**, has the recipient experienced treatment failure (defined as viral relapse, breakthrough while on therapy, or is a non-responder to therapy) with a previous HCV NS5A treatment regimen? ❑ **Yes** ❑ **No**

Technivie® (ombitasvir, paritaprevir and ritonavir)

Does the recipient have a documented diagnosis of chronic hepatitis C genotype 4? ❑ **Yes** ❑ **No**

Will the medication be used in combination with ribavirin? ❑ **Yes** ❑ **No**

Will the recipient receive another HCV direct acting antiviral agent in combination with requested therapy? ❑ **Yes** ❑ **No**

Viekira Pak®, Viekira XR® (ombitasvir, paritaprevir, ritonavir tablets, dasabuvir)

What is the recipient's HCV genotype? ❑ **Genotype 1a** ❑ **Genotype 1b** ❑ **Mixed genotype 1**

Has the recipient experienced treatment failure with a previous regimen that included an NS3/4A protease inhibitor, e.g., Olysio® (simeprevir), Incivek® (telaprevir), Victrelis® (boceprevir)? ❑ **Yes** ❑ **No**

Has the recipient experienced treatment failure (defined as viral relapse, breakthrough while on therapy, or is a non-responder to therapy) with a previous HCV NS5A treatment regimen? ❑ **Yes** ❑ **No**

Will the recipient receive another HCV direct acting antiviral agent in combination with requested therapy? ❑ **Yes** ❑ **No**

Will the medication be used in combination with ribavirin? ❑ **Yes** ❑ **No**

Does the recipient have normal hepatic function with no fibrosis or only mild fibrosis (e.g., METAVIR fibrosis score less than or equal to F2)? ❑ **Yes** ❑ **No** **(submission of documentation required)**

Vosevi® (sofosbuvir/velpatasvir/voxilaprevir)

Will the recipient receive another HCV direct acting antiviral agent in combination with requested therapy? ❑ **Yes** ❑ **No**

Is the recipient a previous relapser to an HCV NS5A treatment regimen? ❑ **Yes** ❑ **No**

Does the recipient have normal hepatic function with no fibrosis or only mild fibrosis (e.g., METAVIR fibrosis score less than or equal to F2)? ❑ **Yes** ❑ **No** **(submission of documentation required)**

Does the recipient have HCV genotype 1a or 3? ❑ **Yes** ❑ **No**

If **yes,** is the recipient a previous relapser to a sofosbuvir-based regimen without an NS5A inhibitor? ❑ **Yes** ❑ **No**

Zepatier® (elbasvir/grazoprevir)

What is the recipient's HCV genotype? ❑ **Genotype 1a** ❑ **Genotype 1b** ❑ **Genotype 4**

If **genotype 1a**, has the recipient been tested for the presence of baseline NS5A resistance associated polymorphisms?
(e.g., polymorphisms at amino acid positions 28, 30, 31, or 93)

❑ **Presence detected**
❑ **Presence NOT detected**
❑ **Recipient has not been tested**

Will the recipient receive another HCV direct acting antiviral agent in combination with requested therapy? ❑ **Yes** ❑ **No**

Will the medication be used in combination with ribavirin? ❑ **Yes** ❑ **No**

Has the recipient experienced treatment failure with a previous regimen that included peginterferon alfa, ribavirin, and an NS3/4A protease inhibitor, e.g., Olysio® (simeprevir), Incivek® (telaprevir), Victrelis® (boceprevir)? ❑ **Yes** ❑ **No**

Has the recipient experienced treatment failure with a previous regimen that included peginterferon alfa and ribavirin only?

❑ **Yes** ❑ **No**

Please attach all supporting documentation to request

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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