HEPATITIS C AGENTS PRIOR AUTHORIZATION FORM

(form effective 1/8/2024)

Keystone First Community HealthChoices | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-855-851-4058**, or to speak to a representative, call **1-866-907-7088**.

Office contact Name/phone:		Prescriber name:		
LTC facility Contact/phone:		State license #:		NPI:
Total # of pages:		Street address:		
Beneficiary name:		City/state/zip:		
Beneficiary ID#:	DOB:	Phone:		Fax:
Requested drug #1:	Directions:		Qty:	☐ 8 weeks ☐ 16 weeks ☐ 12 weeks ☐ Other: _____
Requested drug #2:	Directions:		Qty:	☐ 8 weeks ☐ 16 weeks ☐ 12 weeks ☐ Other: _____
Is the beneficiary currently being treated with the requested drug?			☐ No ☐ Yes — Therapy start date: _____	

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:

Pharmacy Phone #: | Pharmacy Fax #:

☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.

SUBMIT DOCUMENTATION from the medical record for all items below.

For requests for NON-PREFERRED Hepatitis C Agents:

1. **Documentation that the beneficiary tried and failed or has a contraindication or intolerance to the preferred Hepatitis C Agents.** ***(See the Preferred Drug List for the list of preferred Hepatitis C Agents at: https://papdl.com/preferred-drug-list.)***

   List preferred medications tried: _____

2. **Cirrhosis assessment documented by a recent noninvasive test and date of testing.**

3. **Genotype if one of the following (check the appropriate box for the beneficiary):**
   - ☐ The beneficiary is prescribed a non-pangenotypic regimen.
   - ☐ The beneficiary is hepatitis C sofosbuvir-based, sofosbuvir/velpatasvir/voxilaprevir, or sofosbuvir plus glecaprevir/pibrentasvir treatment experienced.
   - ☐ The beneficiary has decompensated cirrhosis and is prescribed ledipasvir/sofosbuvir.
   - ☐ The beneficiary is treatment-naïve (with cirrhosis) and prescribed sofosbuvir/velpatasvir.

4. **RAS (resistance-associated substitutions) testing and date of testing if one of the following (check the appropriate box for the beneficiary):**
   - ☐ The beneficiary is genotype 1a and prescribed elbasvir/grazoprevir.
   - ☐ The beneficiary is genotype 1a, treatment-experienced, and prescribed ledipasvir/sofosbuvir.
   - ☐ The beneficiary is genotype 3, treatment-naïve (with cirrhosis) or treatment-experienced (without cirrhosis) and prescribed 12 weeks of sofosbuvir/velpatasvir.

For requests for THERAPEUTIC DUPLICATION of Hepatitis C Agents direct-acting antivirals (DAAs):

For a beneficiary taking more than one Hepatitis C Agents DAA product concomitantly:

☐ The beneficiary has a medical reason for concomitant use of the requested products that is supported by peer-reviewed medical literature or national treatment guidelines.

ATTESTATION from the prescriber for one of the items below.

Check the appropriate box for the beneficiary.

☐ The beneficiary is hepatitis C treatment naïve.

☐ The beneficiary has been treated for hepatitis C with the following treatment regimen:

_____

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature: | Date: