



1. Complete all 3 (three) pages of this form. Incomplete forms will be returned.
2. Attach required genotype results and biopsy results or other fibrosis test results.
3. Return form and supporting documentation to 410-424-4607 or 410-424-4751.
4. Questions? Contact PP Pharmacy Review at 888-819-1043, option 4.

HEPATITIS C THERAPY PRIOR AUTHORIZATION FORM: Page 1 of 3

Patient Information		
Recipient:	MA#:	
Date of Birth:	Phone #:	Body Weight:
Treatment Plan		
<input type="checkbox"/> Sovaldi [®] (sofosbuvir) 400mg:	Take once daily for _____ weeks	
<input type="checkbox"/> Olysio [®] (simeprevir) 150mg:	Take once daily for _____ weeks	
<input type="checkbox"/> Harvoni [®] :	Take _____ tablet(s) once daily for _____ weeks	
<input type="checkbox"/> Viekira Pak [™] :	Take as directed for _____ weeks	
<input type="checkbox"/> Ribavirin _____ mg:	Take _____ in the morning	
<input type="checkbox"/> Peginterferon alfa _____ mcg:	Inject once weekly for _____ weeks	
<input type="checkbox"/> Daklinza [™] : _____ mg:	Take once daily for _____ weeks	
<input type="checkbox"/> Technivie [™] :	Take 2 tablets once daily for _____ weeks	
<input type="checkbox"/> Zepatier [™] :	Take 1 tablet once daily for _____ weeks	
<input type="checkbox"/> Epclusa [®]	Take 1 tablet once daily for _____ weeks	
<input type="checkbox"/> _____:	Take _____ daily for _____ weeks	
Adherence with prescribed therapy is a condition for payment of therapy for up to the allowed timeframe for each HCV genotype.		
Has a treatment plan been developed and discussed with patient? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Does the patient have any history of medication non-adherence? <input type="checkbox"/> No <input type="checkbox"/> Yes; If yes, please explain:		
Diagnosis		
<input type="checkbox"/> Acute Hep C	<input type="checkbox"/> Chronic Hep C	<input type="checkbox"/> Hepatocellular Carcinoma
<input type="checkbox"/> Liver transplant recipient:	Genotype of pre-transplant liver: _____	
	Genotype of post-transplant liver: _____	
<input type="checkbox"/> Other: _____		
What is the patient's HCV Genotype and subtype? _____		
Has a liver biopsy been performed? <input type="checkbox"/> No <input type="checkbox"/> Yes; Test Date: ____/____/____		
Has a fibrosis test been performed: <input type="checkbox"/> No		
<input type="checkbox"/> Yes; Test used: _____; Test Date: ____/____/____		
Metavir Grade: _____; Metavir Stage: _____		



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Hepatitis C Treatment Plan: Page 3 of 3

Patient's Name: _____	DOB: _____
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Genotype (including subtype): _____

Medications: Please indicate drugs, dose and duration:
(Take or use medications as directed, do not skip a dose)

<input type="checkbox"/> Harvoni®: --Take _____ tablet(s) once daily for _____ weeks
<input type="checkbox"/> Sovaldi® (sofosbuvir) 400mg: – Take once daily for _____ weeks
<input type="checkbox"/> Viekira Pak™: -Take as directed for _____ weeks
<input type="checkbox"/> Olysio® (simeprevir) 150mg: – Take once daily for _____ weeks
<input type="checkbox"/> Ribavirin _____ mg – Take _____ in the morning and _____ in the afternoon for
<input type="checkbox"/> Peginterferon alfa _____ mcg: -- Inject once weekly for _____ weeks
<input type="checkbox"/> Daklinza™ _____ mg: --Take once daily for _____ weeks
<input type="checkbox"/> Technivie™ : --Take two tablets once daily for _____ weeks
<input type="checkbox"/> Zepatier™:--Take once daily for _____ weeks
<input type="checkbox"/> Epclusa®:--Take once daily for _____ weeks
<input type="checkbox"/> Other:

Laboratory Testing – Indicate week during which labs should be completed
 HCV levels must be obtained at Treatment weeks 4, 12 and 24 (if necessary)

Week 4 - _____ (please insert due date)
Week 12 - _____ (please insert due date)
Week 24 (if indicated) - _____ (please insert due date)
SVR upon completion of therapy - _____ (please insert due date)

HCV Genotype and Comorbidities	Treatment	Duration
Patients with genotype 1 HCV	sofosbuvir + peginterferon alfa + ribavirin OR simeprevir + peginterferon alfa + ribavirin	12 weeks OR 12 weeks of simeprevir and 24 to 48 weeks of peginterferon alfa + ribavirin
Patients with genotype 1 HCV and interferon ineligible	sofosbuvir + ribavirin	24 weeks
Patients with genotype 2 HCV	sofosbuvir + ribavirin	12 weeks
Patients with genotype 3 HCV	sofosbuvir + ribavirin	24 weeks
Patients with genotype 3 HCV, without cirrhosis	daclatasvir + sofosbuvir	12 weeks
Patients with genotype 4 HCV	sofosbuvir + peginterferon alfa + ribavirin	12 weeks
Patients with genotype 4 HCV	Ombitasvir/paritaprevir/ritonavir + ribavirin	12 weeks
Patients with hepatocellular carcinoma awaiting liver transplantation	sofosbuvir + ribavirin	48 weeks (or until the time of liver transplantation; whichever occurs first)

HCV Prior Authorization Provider Checklist

Dear Provider,

In order to facilitate the approval of medications to treat your patient's HCV, please utilize the following checklist to ensure you have included all necessary documentation.

For start of treatment:

- Completed PA form
- Completed treatment plan (recommended not required for initial therapy)
- Baseline lab values (within last 75 days)
- HCV genotype
- Fibrosis score documentation (fibrosure or biopsy results)
- Recent (within last 3 months) provider note

For refill authorization:

In order to continue on the HCV therapy, patient is required to have follow up labs.

- Lab values between 2 to 4 weeks after initiation of therapy
- Lab values after 12 weeks of therapy (for 24 week treatment)

In cases of retreatment, additional viral load values will be requested at week 2 and 6.