Texas Standard Prior Authorization Form – Initial Request
Antiviral Agents for Hepatitis C Virus

Superior follows the Texas Vendor Drug Program clinical prior authorization criteria for Hepatitis C medications.

Please complete and **fax all required documents to Envolve Pharmacy Solutions at (866) 399-0929** for initial prior authorization requests. **Prior authorization will be granted for 6 weeks duration.** Labs are required for weeks 0, 4, and 12 of therapy. For refill authorizations please use the **Texas Standard Prior Authorization Form - Refill Request.**

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1. Client Information

Name (Last, First):	Medicaid ID #:	
Diagnosis (ICD-10):	Date of initial diagnosis: (mm/dd/ccyy)	
Date of Birth: (mm/dd/ccyy)	Gender: ☐ Male ☐ Female	Current Weight: ☐ lb ☐ kg

2. Prescriber Information

Name:	NPI #:	State license #:
Phone:	Fax:	Provider Specialty:
Consulting/Supervising Physician (if applicable):	Name:	Phone:

3. Laboratory *(Results below must be from the previous 90 days)*

Laboratory Test	Value	Date	Laboratory Test	Value	Date
Baseline HCV RNA level			INR		
ALT			HCT		
AST			Hgb		
AlkPhos			RBC		
CrCl			Plt		
SCr			Albumin		
Total bilirubin					

4. Current Patient Status (check all that apply):

☐ Hepatocellular carcinoma ☐ HIV co-infection ☐ Hepatitis B co-infection
☐ Awaiting liver transplant ☐ Previous liver transplant(s) ☐ Compensated cirrhosis
☐ Decompensated cirrhosis ☐ End stage renal disease requiring hemodialysis
☐ Partial responder ☐ Relapsed ☐ Null responder

a. If patient has been previously treated for HCV, is the previous treatment regimen(s) known?
☐ Yes ☐ No ☐ N/A
i. If yes, list medications used and any known dates of treatment below.

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5. Additional Required Information

a. HCV Genotype:
☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 Date of testing: _____
(*Results must be from previous 5 years)*

b. Metavir Fibrosis Stage*:
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 Date of testing: _____
*__Documentation of Metavir stage results must be submitted.__

Approved documentation includes the following options. Requests that do not include one of the approved methods above for Metavir staging, or that do not result in a definitive Metavir stage will be reviewed for acceptance on a case by case basis.

☐ A single biopsy *(results must be from the **previous 5 years**)*

OR

☐ One of the following non-invasive tests (*results must be from the **previous 2 years***):
FibroSURE, Fibrospect, Fibrometer, Fibroscan, or Sheer Wave Elastography.

c. Q80K polymorphism, for Olysio requests:
☐ Positive ☐ Negative ☐ N/A Date of testing: _____
(Results must be from previous 2 years)

d. NS5A resistance testing in HCV genotype 1a, for Daklinza or Zepatier requests
☐ Positive ☐ Negative ☐ N/A Date of testing: _____
(Results must be from previous 2 years)

Results for items e through h, below, must be from the previous 90 days

e. Child-Turcotte-Pugh Score
☐ A (5-6 points) ☐ B (7-9 points) ☐ C (10-15 points) Date of assessment: _____

f. Pregnancy Test Results: ☐ Positive ☐ Negative ☐ N/A Date of testing: _____

g. Drug Test Results: ☐ Positive ☐ Negative Date of testing: _____

h. Has the patient been assessed for hepatitis B virus coinfection?
☐ Yes ☐ No Date of assessment: _____
If yes, does the patient require concurrent hepatitis B virus treatment?
☐ Yes ☐ No

6. Prescribing Information

Preferred Hepatitis C Agents	
Direct Acting Antiviral	**Other**
Daklinza (daclatasvir)[5] Epclusa (sofosbuvir/velpatasvir)* **Epclusa is preferred for genotypes 2 and 3 only* Technivie (ombitasvir/paritaprevir/ritonavir) Viekira Pak (ombitasvir/paritaprevir/ritonavir and dasabuvir) Viekira XR (ombitasvir/paritaprevir/ritonavir and dasabuvir)	PEG-Intron (peginterferon alfa-2b) ribavirin capsule/tablet
Non-Preferred Direct Acting Antivirals	
Harvoni (sofosbuvir/ledipasvir), Olysio (simeprevir), Sovaldi (sofosbuvir), Zepatier (elbasvir/grazoprevir)	

In the table below, specify all drug(s) being requested in the hepatitis C regimen and indicate the duration of therapy.

Requested Drug Name(s)	Requested duration of therapy (weeks)
1.	
2.	
3.	

Selection of products other than the preferred products above may be appropriate for patients in whom a preferred regimen is not indicated. Request for a product other than a preferred product does not guarantee coverage. If requesting a product other than a preferred product from above, please provide the rational below. **Failure to provide justification may result in denial of prior authorization.**

7. Required documents for submission for initial prior authorization request:

- ☐ Completed Initial Request PA Form
- ☐ Completed Prescriber Certification
- ☐ Copy of Metavir fibrosis stage results
- ☐ If applicable, copy of specialist consult

8. Prescriber Signature

Provider signature: _____ Date: _____

*Provider signature indicates provider attests to all information outlined in the **Antiviral Agents for Hepatitis C Virus Prior Authorization Form, Prior Authorization Criteria and Policy,** and **Patient Education for Hepatitis C Treatment Prescriber Certification** documents.*