Texas Standard Prior Authorization Form – Initial Request

Antiviral Agents for Hepatitis C Virus

envolve Pharmacy Solutions

Please complete and **fax all required documents to Envolve Pharmacy Solutions at 1-866-399-0929** for initial prior authorization requests. **Prior authorization will be granted for 6 weeks duration.** Labs are required for weeks 0, 4 and at week 12 for treatments lasting longer than 12 weeks. For refill authorizations please use the *Hepatitis C Virus Refill Prior Authorization Request*.

1. Client Information

Name (Last, First):		Medicaid ID No.:	Diagnosis (ICD-10):
Date of Initial Diagnosis:	Date of Birth:	Gender: ◯ Male ◯ Female	Current Weight: ◯ lb ◯ kg

2. Prescriber Information

Name:	NPI No.:	State License No.:
Area Code and Telephone No.:	Area Code and Fax No.:	Provider Specialty:
Consulting/Supervising Physician, if applicable:	Name:	Area Code and Telephone No.:

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
- ☐ Null responder
- ☐ Partial responder
- ☐ Relapsed

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.

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, Fibrotest 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) ◯ N/A Date of testing: _____

f. Pregnancy Test:

◯ Positive ◯ Negative ◯ N/A Date of testing: _____

g. Drug Test:

◯ Positive ◯ Negative ◯ N/A Date of testing: _____

h. Has the patient been assessed for hepatitis B virus coinfection?

◯ Yes ◯ No Date of testing: _____

If yes, does the patient require concurrent hepatitis B virus treatment? ◯ Yes ◯ No

6. Prescribing Information

Preferred Products
• Epclusa (sofosbuvir/velpatasvir)***** • Mavyret (glecaprevir/pibrentasvir) • Vosevi (Sofosbuvir/velpatasvir/voxilaprevir)
*** See package insert for FDA indications**

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.**

8. Required documents for submission for initial prior authorization requests:

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

9. Prescriber Signature

Provider Signature: _____ Date: _____

*Provider signature indicates provider attests to all information outlined in Parts I (**Prior Authorization Criteria**), II (**Prescriber Certification of Patient Education for Hepatitis C Treatment**), and III (**Initial Prior Authorization Request**) of Form 1335.*