

# Texas Standard Prior Authorization Form – Initial Request

## Antiviral Agents for Hepatitis C Virus



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 12 of therapy. For refill authorizations please use the *Prior Approval Refill Request Form*.

### 1. Client Information

Name (Last, First):		Medicaid ID Number:	
Diagnosis (ICD-10):		Date of Initial Diagnosis: (mm/dd/ccyy)	
Date of Birth: (mm/dd/ccyy)	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Current Weight: _____ <input type="checkbox"/> lb <input type="checkbox"/> kg	

### 2. Prescriber Information

Name:		NPI Number:	State License Number:
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):

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Hepatocellular carcinoma  | <input type="checkbox"/> HIV co-infection             | <input type="checkbox"/> Hepatitis B co-infection                       |
| <input type="checkbox"/> Awaiting liver transplant | <input type="checkbox"/> Previous liver transplant(s) | <input type="checkbox"/> End stage renal disease requiring hemodialysis |
| <input type="checkbox"/> Decompensated cirrhosis   | <input type="checkbox"/> Compensated Cirrhosis        | <input type="checkbox"/> Null responder                                 |
| <input type="checkbox"/> Partial responder         | <input type="checkbox"/> 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.

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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, 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) ☐ C (10-15 points)

Date of assessment: \_\_\_\_\_

- f. Pregnancy Test: ☐ Positive ☐ Negative ☐ N/A

Date of testing: \_\_\_\_\_

- g. Drug Test: ☐ 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

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### 6. Prescribing Information

Preferred Hepatitis C Agents	
Direct Acting Antiviral	Other
Epclusa (sofosbuvir/velpatasvir)* <i>*Epclusa is preferred for genotypes 2 and 3 only</i> 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), Daklinza (daclatasvir)	

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 rationale 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.