Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
HCV Antivirals for Treatment of Hepatitis C Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- Standard length of treatment; Continuation- N/A

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **HCV Antivirals for Treatment of Hepatitis C.** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: http://pithelp.appl.kp.org/MAS/formulary.html**

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Is the prescriber a gastroenterologist, hepatologist, or infectious disease specialist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Provider Name: _____ Specialty: _____NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Please check the boxes that apply:
□ Initial Request □ Continuation of Therapy Request

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

□ Eplcusa (sofosbuvir/velpatasvir) □ Mayvret (glecaprevir) □ Vosevi (sofosbuvir/velpatasvir/voxilaprevir)
□ Daklinza (daclatasvir) □ Harvoni (ledipasvir/sofosbuvir) □ Sovaldi (sofosbuvir)
□ Viekira (ombitasvir/paritaprevir/ritonavir/dasabuvir) □ Zepatier (elbasvir/grazoprevir)

Drug 1: Name/Strength: _____ Quantity Limit:_____ Sig:_____
Treatment Length: _____Start Date:_____

Drug 2: Name/Strength: _____ Quantity Limit:_____ Sig:_____
Treatment Length: _____Start Date:_____

6 – Diagnosis/Clinical Criteria

Initial Therapy:

1. Is this member 18 years of age or older (members <18 years should be prescribed by a pediatric gastroenterologist)?
   □ No □ Yes
2. Does the member have detectable HCV RNA level (if patient has evidence of prescriptions for past HCV treatment, the detectable HCV RNA level must be from at least 12 weeks after completion of the previous treatment or appropriate at the discretion of the reviewing Hepatitis C Clinical Pharmacist)? AND
   □ No □ Yes
3. Does the member NOT have a limited life expectancy (i.e., <12 months) due to non-liver related comorbid conditions? AND
   □ No □ Yes
4. Does the member have confirmation of test for HBV infection by measuring HBsAg and anti-HBc within 6 months of treatment or appropriate at the discretion of Hepatitis C Clinical Pharmacist review?
   □ No □ Yes
5. Does the requested drug correlate to current Kaiser Permanente HCV preferred therapies, based on genotype, therapy history? AND
   □ No □ Yes
6. Has the cirrhosis status been reviewed by Hepatitis C Clinical Pharmacist?
   □ No □ Yes

Continuation of Therapy:

1. None; initial approval based on standard length of treatment course

7 – Provider Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration.

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**