Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Hepatitis C Agents Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk

KAISER PERMANENTE®

Instructions:
This form is used by Kaiser Permanente and/or participating providers for coverage of **Hepatitis C Agents.** 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**

MEMBER INFORMATION

Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐ **First Name:** ☐☐☐☐☐☐☐☐☐☐☐☐

Kaiser Permanente MRN Number: ☐☐☐☐☐☐☐☐☐☐☐☐ **Date of Birth:** ☐☐ – ☐☐ – ☐☐☐☐

Gender: ☐ **Male** ☐ **Female** **Member Age:** ___________________________________

Is the member pregnant, breastfeeding, or planning to breastfeed?

☐ Yes ☐ No

PRESCRIBER INFORMATION

Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐ **First Name:** ☐☐☐☐☐☐☐☐☐☐☐☐

NPI Number: ☐☐☐☐☐☐☐☐☐☐

Phone Number: ☐☐☐ – ☐☐☐ – ☐☐☐☐ **Fax Number:** ☐☐☐ – ☐☐☐ – ☐☐☐☐

Prescriber Specialty: Indicate the prescriber's specialty or in consultation with:

☐ Gastroenterologist ☐ Hepatologist ☐ Transplant Specialist ☐ Infectious Disease ☐ Generalist

☐ Other: ____

Note: Non-Preferred hepatitis C medication must be prescribed by one of the specialty physicians or in consultation with the specialty prescribers listed above.

Provider Signature____

DRUG INFORMATION

The preferred hepatitis C drugs listed below can be prescribed by a generalist without specialty consultation.

☐ **Mavyret (Glecaprevir/Pibrentasvir)** ☐ **Sofosbuvir/Velpatasvir**

Drug Name/Form: ____

Strength: ____

Dosing Frequency: ____

Length of Therapy: ____

Quantity per Day: ____

DIAGNOSIS

☐ Acute or Chronic Hepatitis C ☐ Compensated cirrhosis ☐ Hepatocellular carcinoma
☐ Decompensated cirrhosis (Child-Pugh score class B or C) ☐ Status post-liver transplant
☐ Severe renal impairment (eGFR <30 mL/min/1.73m^2) or end stage renal disease requiring hemodialysis

HCV Genotype:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

Choose One: ☐ Treatment initiation ☐ Continuation of therapy, current week: ________________

(For your information only) Hepatitis C Complexity Review: If a patient meets any of these criteria, they may benefit from specialty consultation.

- ☐ Patient is coinfected with Hepatitis B
- ☐ Patient is pregnant, breastfeeding, or planning to breastfeed
- ☐ Patient is taking atazanavir or rifampin
- ☐ Patient has severe kidney problems or is on dialysis
- ☐ Patient has HIV
- ☐ Patient has severe decompensated liver cirrhosis or a Child-Pugh score class B or C

PREVIOUS HEPATITIS C TREATMENTS

☐ **Treatment naïve** ☐ **Treatment Experienced with (check all that apply):**

☐ Daklinza™ (daclatasvir)	☐ Olysio™(simeprevir)
☐ Epclusa® (sofosbuvir/velpatasvir)	☐ peginterferon
☐ Harvoni® (ledipasvir-sofosbuvir)	☐ ribavirin
☐ Incivek® (telaprevir)	☐ sofosbuvir/velpatasvir
☐ Interferon	☐ Sovaldi® (sofosbuvir)
☐ ledipasvir-sofosbuvir	☐ Technivie® (ombitasvir/paritaprevir/ritonavir)
☐ Viekira Pak™ (ombitasvir/paritaprevir/ritonavir) with dasabuvir	☐ Viekira XR™ (ombitasvir/paritaprevir/ritonavir; dasabuvir)
☐ Zepatier™ (elbasvir and grazoprevir)	

Document dates received treatment: ____

____   ________________________

Prescriber Signature (Required)   **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.