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

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Hepatitis C Drugs.**
Please complete all sections, incomplete forms will delay processing. 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 all sections are complete.**
KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

Please attach copies of the recent provider notes, patient's medical history summary, lab and genetic test reports.

1- Patient Information

Patient Name: _____ MA#: _____ Kaiser Medical ID#: _____

Date of Birth: _____ Body Weight: _____ kg Phone #: _____

2- Provider information

Provider Name: _____ Specialty: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

3- Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4- Drug Therapy Selection (Include all that apply if more than 1 drug is prescribed)

Drug 1: Name/Strength_____ Quantity Limit: _____Sig: _____

Treatment Length: _____ Start Date: _____

Drug 2: Name/Strength_____ Quantity Limit: _____Sig: _____

Treatment Length: _____ Start Date: _____

Drug 3: Name/Strength_____ Quantity Limit: _____Sig: _____

Treatment Length: _____ Start Date: _____

5- Diagnosis

For pediatric use: Is the patient 3 years of age or older? □ No □ Yes
(Epclusa, Harvoni, Mavyret are indicated for patients ≥ 3 years old)

□ Acute Hep C □ Chronic Hep C (Hep C present for ≥ 6 months) established by (please select one)

□ HCV antibody: Test date: _____/_____/_____

□ HCV RNA: Test date: _____/_____/_____

□ HCV diagnosis date: _____/_____/_____

□ Exposure risk history assessment date: _____/_____/_____

□ Liver transplant recipient: Genotype of pre-transplant liver: _____

Genotype of post-transplant liver: _____

□ Other:_____

What is the patient's HCV genotype and subtype? _____

Has a liver biopsy been performed? □ No □ Yes; Test date: _____/_____/_____

Has a fibrosis test been performed: □ No □ Yes; Test used: _____; Test date : _____/_____/_____

Metavir Grade: _____; Metavir Stage: _____

What best describes this patient's liver disease? (Check all that apply):

□ No cirrhosis □ Compensated cirrhosis □ Decompensated liver disease

***Please provide a copy of the results of the biopsy, genotype and any other fibrosis tests for this patient. ***

6- Treatment Plan (Select all that apply)

Chronic Hepatitis C Genotype: 1, 4, 5, 6	□ Harvoni (Ledipasvir/Sofosbuvir)
Chronic Hepatitis C Genotype 1, 4	□ Zepatier (Elbasvir/Grazoprevir)
Chronic Hepatitis C Genotype 1-6	□ Epclusa (Sofosbuvir/Velpatasvir)
Chronic Hepatitis C Genotype 1-6 treatment naïve and experienced	□ Mavyret (Glecaprevir/Pribrentasvir)
Chronic Hepatitis C Genotype 1-6 prior DAA treatment experienced with a NS5A inhibitor or Sofosbuvir	□ Vosevi (Sofosbuvir/Velpatasvir/Voxilaprevir)

Ribavirin _____ mg: Take _____ in the morning and _____ in the afternoon for _____ weeks

PegIFN _____mcg: Inject once weekly for _____ weeks

Has a treatment plan been developed and discussed with patient? □ No □ Yes

Does the patient have any history of medication non-adherence? □ No □ Yes: If yes, please explain the details of non-adherence and how will it be addressed: _____

_____

Note: Drug Therapy must be in accordance to FDA approved indications for the specific genotype

7- Hepatitis C Treatment History

Has this patient been treated for Hepatitis C in the past? □ Treatment Naive □ Treatment Experienced

If Treatment-Experienced, what was the outcome of the previous treatments:

□ Relapsed □ Partial Responder □ Non-Responder □ Toxicities □ Reinfection

Genotype pre-DAA therapy and Date: _____

Genotype post-DAA therapy and Date: _____

Complete table included for prior HCV treatment regimen(s):

HCV Treatment	Duration	Dates	Outcome	Post-treatment HCV RNA Result and Date
			□ Relapsed □ Partial Responder □ Non-Responder □ Toxicities □ Reinfection Other_____	
			□ Relapsed □ Partial Responder □ Non-Responder □ Toxicities □ Reinfection Other_____	

8- Laboratory Results

Type of Test	Result	Date
Baseline HCV RNA level (within 180** days of treatment)		
Baseline total bilirubin (only in cirrhotic patient)		
Baseline albumin (only in cirrhotic patient)		
Baseline INR (only in cirrhotic patient)		
CBC (only in ribavirin containing regimen) Baseline hemoglobin		
Baseline hematocrit		
Baseline platelet		
Child-Pugh Score (Child-Pugh Status of A required for patients with cirrhosis (stage 4 by Metavir) for Zepatier, Mavyret, Vosevi; Child-Pugh Status of A for compensated cirrhosis for Epclusa; Child-Pugh Status of B and C for decompensated cirrhosis for Epclusa)		
NS5A Polymorphisms Zepatier when applicable		

****unless the patient is cirrhotic then the baseline lab values must be <u>within 90 days of prior authorization request.</u>**

9- Medical History

Is the patient co-infected with HIV? □ No □ Yes; If yes, HIV status: _____

HIV viral load: _____ Date drawn: _____

Current antiretroviral regimen: _____

Is the patient co-infected with HBV? □ No □ Yes; If yes, HBV status: _____

HBV viral load: _____ Date drawn: _____

Current antiretroviral regimen: _____

Is the patient co-infected with other viral infection: _____

Had patient had a solid organ transplant? □ No □ Yes; specify type of transplant _____

Date of Transplant: _____

10- Provider Sign off

If the patient's Medicaid eligibility changes during therapy and the patient is no longer eligible for Medicaid prescription drug assistance, is the physician prepared to enroll the patient in other patient assistant drug programs to complete therapy? □ Yes □ No

Contact Person at your office: (name):_____Telephone #:_____

For continuation of therapy approval, provider must submit viral load completed at or between weeks two and six of therapy. □ Yes □ No

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

Provider Signature:	**Date:**