

MASSACHUSETTS STANDARD FORM FOR HEPATITIS C MEDICATION PRIOR AUTHORIZATION REQUESTS

**Some plans might not accept this form for Medicare or Medicaid requests.*

A. Destination	
Health Plan or Prescription Plan Name: Mass General Brigham Health Plan	
Health Plan Phone: 866-814-5506	Health Plan Fax: 866-249-6155

B. Patient Information		
Patient Name:	DOB:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____
Member ID #:		

C. Prescriber Information	
Prescribing Clinician:	Phone #:
Specialty:	Secure Fax #:
NPI #:	DEA #:
Prescriber Point of Contact Name (POC) (if different than prescriber):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
Prescribing Clinician or Authorized Representative Signature:	
Date:	

D. Medication Information
Check if Expedited Review/Urgent Request: <input type="checkbox"/> (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)
<input type="checkbox"/> Daklinza <input type="checkbox"/> Epclusa <input type="checkbox"/> Harvoni <input type="checkbox"/> Olysio <input type="checkbox"/> Ribavirin Generic <input type="checkbox"/> Ribavirin Branded <input type="checkbox"/> Sovaldi <input type="checkbox"/> Technivie <input type="checkbox"/> Viekira Pak <input type="checkbox"/> Viekira XR <input type="checkbox"/> Zepatier <input type="checkbox"/> Other _____
Requested Duration of Treatment: _____ weeks
Type of Therapy: <input type="checkbox"/> Initial <input type="checkbox"/> Continuation — weeks remaining: _____
Anticipated or actual start date:
Is the medication prescribed by, or in consultation with, a gastroenterologist, infectious disease specialist, or hepatologist? <input type="checkbox"/> Yes <input type="checkbox"/> No
For Zepatier only: Has there been confirmation that the patient does not have a genotype 1a with a baseline NS5A polymorphism? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
For Ribavirin only: Does the patient require a dosage form other than generic ribavirin 200 mg capsules or tablets? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify the following: Dosage form requested: _____ Clinical reason for use: _____
Are any of the following statements true? <input type="checkbox"/> Patient is pregnant or plans to become pregnant within 6 months of completing treatment <input type="checkbox"/> Patient is male with a female partner who is pregnant or plans to become pregnant within 6 months of completing treatment <input type="checkbox"/> Patient has contraindications or intolerance to Ribavirin

E. Patient Clinical Information

**Please refer to plan-specific criteria for details related to required information.*

Diagnosis: B18.2 Hepatitis C (chronic) Other: _____

HCV Genotype: 1 1a 1b 2 3 4 5 6

Stage of Hepatic Fibrosis: F0 F1 F2 F3 F4

If F 4: Compensated Decompensated

Check all methods of assessment that apply and include result:

Method	Result
<input type="checkbox"/> Liver biopsy	See above
<input type="checkbox"/> Transient elastography (FibroScan)	_____ kPa
<input type="checkbox"/> Shear wave elastography	_____ kPa
<input type="checkbox"/> MRE	_____ kPa
<input type="checkbox"/> FibroSure (FibroTest)	_____
<input type="checkbox"/> Echosens Fibrometer	_____
<input type="checkbox"/> Fibrospect	_____
<input type="checkbox"/> APRI	_____
<input type="checkbox"/> Fib-4	_____
<input type="checkbox"/> Hepascore	_____
<input type="checkbox"/> Other: _____	_____

Does the patient have HIV coinfection? Yes No Unknown

Is the patient status post liver transplant? Yes No

Confirm the patient's GFR range: 0-14 15-29 30 or greater (Please specify.) _____

HCV RNA levels:

Baseline (most recent): _____ IU/mL Date of lab work: _____

Week 8 of treatment (if continuation request): _____ IU/mL Date of lab work: _____

Previous Treatments

Has the patient been previously treated for Hepatitis C and failed treatment? Yes No

Adverse Reaction? Yes No

Drug Name	Date of treatment (MM/YY)	Response to treatment
		<input type="checkbox"/> Relapsed <input type="checkbox"/> Partial response <input type="checkbox"/> Null response (<2 log reduction in HCV RNA at Week 12) <input type="checkbox"/> Did not complete <input type="checkbox"/> Briefly describe details: _____
		<input type="checkbox"/> Relapsed <input type="checkbox"/> Partial response <input type="checkbox"/> Null response (<2 log reduction in HCV RNA at Week 12) <input type="checkbox"/> Did not complete <input type="checkbox"/> Briefly describe details: _____
		<input type="checkbox"/> Relapsed <input type="checkbox"/> Partial response <input type="checkbox"/> Null response (<2 log reduction in HCV RNA at Week 12) <input type="checkbox"/> Did not complete <input type="checkbox"/> Briefly describe details: _____

Additional information pertinent to this request:

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.