

OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: *The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.*

Hepatitis-C Antiviral Drugs (Non-Preferred) (COMMERCIAL ONLY)

DRUG REQUESTED: Check applicable box below for Hepatitis-C therapy:			
<input type="checkbox"/> Daklinza™	<input type="checkbox"/> Epclusa®	<input type="checkbox"/> Harvoni®	<input type="checkbox"/> Olysio™
<input type="checkbox"/> Sovaldi®	<input type="checkbox"/> Technivie™	<input type="checkbox"/> Viekira Pak™	<input type="checkbox"/> Viekira XR™
<input type="checkbox"/> Vosevi®	<input type="checkbox"/> Zepatier®	<input type="checkbox"/> peginterferon alfa	<input type="checkbox"/> ribavirin

DRUG INFORMATION: Complete information below. Authorization process will be delayed if incomplete.

Drug Name: _____
 Drug Form/Strength: _____ Quantity per Day: _____
 Dosing Schedule: _____ Length of Therapy: _____
 Diagnosis: _____ ICD Code, if applicable: _____

- *Optima Health coverage criteria for the new direct-acting agents are based on careful consideration of the evidence-based guidance of professional specialty societies, published guidelines, and physician subject matter experts specialists.*
- **ONE TIME APPROVAL FOR ANY and ALL DIRECT-ACTING ANTIVIRAL (DAA) PER LIFETIME (EXCEPTION)**

CLINICAL CRITERIA: Check **ALL** boxes below to qualify. **ALL** pertinent chart notes and lab values **MUST** be included in this request or authorization process will be delayed. Check applicable box(es) below for **previous Hepatitis-C treatments/therapy:**

<input type="checkbox"/> Daklinza™	<input type="checkbox"/> Epclusa®	<input type="checkbox"/> Harvoni®	<input type="checkbox"/> Incivek®
<input type="checkbox"/> Olysio™	<input type="checkbox"/> Sovaldi®	<input type="checkbox"/> Technivie™	<input type="checkbox"/> Victrelis®
<input type="checkbox"/> Viekira Pak™	<input type="checkbox"/> Viekira XR™	<input type="checkbox"/> Vosevi®	<input type="checkbox"/> Zepatier®
<input type="checkbox"/> peginterferon alfa	<input type="checkbox"/> ribavirin		

- **Treatment is being prescribed by (check applicable box below):**

<input type="checkbox"/> Gastroenterologist	<input type="checkbox"/> Hepatologist	<input type="checkbox"/> ID Specialist
<input type="checkbox"/> Transplant Specialist	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Other: _____

- Patient is: treatment naïve relapse treatment experienced
- **Patient tried and failed PREFERRED drug (Mavyret™)**
- Patient has a diagnosis of chronic HCV genotype. 1 2 3 4 5 6 (**Labs must be included**)
- A documented viral load (HCV RNA) taken within 6 months of beginning therapy (**Include labs**)
- Is member co-infected with hepatitis B (**send labs**) Yes No
- Is member co-infected with HIV-1? Yes No
- Has patient ever been successfully treated for chronic HCV? Yes No
- Does patient have hepatocellular carcinoma or severe cirrhosis awaiting a liver transplant? Yes No
- Does patient have compensated cirrhosis? (**Include labs**) Yes No
- Does patient has decompensated cirrhosis (which is defined as a Child-Pugh score greater than 6 [class B or C])? (**Include labs**) Yes No
- Is patient free from illicit substance abuse for at least **6 months**? (**submit labs within last 30 days**) Yes No
- Is patient free from alcohol abuse for at least **6 months**? (**submit labs within last 30 days**) Yes No
- **If the answer to either of the 2 questions above is NO, then evidence of lack of substance abuse during therapy is required including a negative urine toxicology screening confirmation test immediately prior to DDA therapy and monthly for two months after beginning treatment (Results must be submitted with request)**

(continued on next page)

For assessment of disease severity, please refer to the table below for a Fibrosis/stage score:

Metavir	Scheuer/Batts, Ludwig/Tsui Stage	Ishak, et al: Fibrosis Scoring	Knodell et al: Fibrosis Scoring
F0=no fibrosis	0=No fibrosis, normal amount of connective tissue	0=No fibrosis	0=No fibrosis
F1=portal fibrosis without septa	1=Portal/periportal fibrosis	1=Expansion of some portal areas with or without septa	1=Fibrous some portal expansion with or without septa
F2=portal fibrosis with rare septa	2=Septal fibrosis	2=Expansion of most portal areas with or without septa	2= Fibrous most portal expansion with or without septa
F3=numerous septa, not cirrhosis	3=Bridging fibrosis with architectural distortion.	3=Expansion of most portal areas with occasional portal to portal bridging	3=Bridging Fibrosis
F4=cirrhosis	4=Cirrhosis, probable cirrhosis	4=Expansion of portal areas with marked bridging (portal-portal and/or portal-central)	4=Cirrhosis
		5=Marked bridging with occasional nodules (incomplete cirrhosis)	
		6=Cirrhosis, probable or definitive	

Cirrhosis requires 2 liver assessments with Lab values & symptoms correlating with Cirrhosis. Submit a Liver assessment documenting fibrosis including one (1) of the following: *(Please Note: Contra-Indication to a liver assessment would lead to an incomplete form.)*

Liver biopsy confirming:

<input type="checkbox"/> METAVIR score	<input type="checkbox"/> Knodell fibrosis score (last #-reported separately)
<input type="checkbox"/> Ishak stage	<input type="checkbox"/> Batts-Ludwig stage

- Transient elastography (FibroScan) score of: _____ kPa
- FibroTest (FibroSure) score of: _____ (*Alcohol test **MUST** be same date of FibroTest*)
- Shear wave elastography (ElastPQ) score of: _____ m/s
- Shear wave (SWE supersonic tech) score of: _____ m/s
- Shear wave (VTTQ) Siemens score of: _____ m/s
- LABS need to be submitted with this request form for the following:** **CBC** **BMP**

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

*Approved by Pharmacy and Therapeutics Committee: 10/19/2017
REVISED/UPDATED: 12/30/2017