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:***			
❑ **Daklinza™**	❑ **Epclusa®**	❑ **Harvoni®**	❑ **Olysio™**
❑ **Sovaldi®**	❑ **Technivie™**	❑ **Viekira Pak™**	❑ **Viekira XR™**
❑ **Vosevi®**	❑ **Zepatier®**	❑ **peginterferon alfa**	❑ **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:			
❑ **Daklinza™**	❑ **Epclusa®**	❑ **Harvoni®**	❑ **Incivek®**
❑ **Olysio™**	❑ **Sovaldi®**	❑ **Technivie™**	❑ **Victrelis®**
❑ **Viekira Pak™**	❑ **Viekira XR™**	❑ **Vosevi®**	❑ **Zepatier®**
❑ **peginterferon alfa**	❑ **ribavirin**		

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

❑ **Gastroenterologist**	❑ **Hepatologist**	❑ **ID Specialist**
❑ **Transplant Specialist**	❑ **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**:

❑ METAVIR score	❑ Knodell fibrosis score (last #-reported separately)
❑ Ishak stage	❑ 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