



**Cirrhosis requires 2 liver assessments with Lab values & symptoms correlating with Cirrhosis. Liver assessment MUST be submitted to determine length of therapy. One of the following liver assessments MUST be submitted. (Please Note: Contra-Indication to a liver assessment would lead to a denial.)**

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)
- FibroTest (FibroSure) - alcohol test **MUST** be submitted same day as the FibroSure test
- Shear wave elastography (ElastPQ)
- Shear wave (SWE supersonic tech)
- Shear wave (VTTQ) Siemens

**Treatment Naïve Patients:**

HCV Genotype	Treatment Duration	
	No Cirrhosis	Compensated Cirrhosis (Child-Pugh A)
1, 2, 3, 4, 5, or 6	8 weeks	12 weeks

**Treatment Experienced Patients**

HCV Genotype	Patients Previously Treated With a Regimen Containing:	Treatment Duration	
		No Cirrhosis	Compensated Cirrhosis (Child-Pugh A)
1	An NS5A inhibitor <sup>1</sup> without prior treatment with an NS3/4A protease inhibitor	16 weeks	16 weeks
	An NS3/4A PI <sup>2</sup> without prior treatment with an NS5A inhibitor	12 weeks	12 weeks
1, 2, 4, 5, or 6	PRS <sup>3</sup>	8 weeks	12 weeks
3	PRS <sup>3</sup>	16 weeks	16 weeks

1. In clinical trials, subjects were treated with prior regimens containing ledipasvir and sofosbuvir or daclatasvir with pegylated interferon and ribavirin.
2. In clinical trials, subjects were treated with prior regimens containing simeprevir and sofosbuvir, or simeprevir, boceprevir, or telaprevir with pegylated interferon and ribavirin.
3. PRS=Prior treatment experience with regimens containing interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A PI or NS5A inhibitor.

**\*\*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 #: \_\_\_\_\_