



## PRIOR AUTHORIZATION REQUEST FORM Hepatitis C Therapy

DATE OF REQUEST: \_\_\_\_\_

MEMBER INFORMATION

MEMBER NAME \_\_\_\_\_

ID # \_\_\_\_\_

BIRTHDATE \_\_\_\_\_

**PLEASE NOTE:** By signing this form, you are attesting to the accuracy of the information provided, and that medical record documentation is available if requested.

PROVIDER INFORMATION

NAME \_\_\_\_\_

NPI # \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE # \_\_\_\_\_ FAX # \_\_\_\_\_

CONTACT NAME \_\_\_\_\_

PROVIDER SIGNATURE \_\_\_\_\_

**Drug Requested**    RIBAVIRIN \*    PEGASYS®\*    COPEGUS®    PEG INTRON®    REBETOL®  
 (\* preferred agent)

<b>Request for Initial Therapy</b>		
Viral Load _____	Date: _____	(attach corresponding labs)
Genotype (please circle):    1a or 1b       2       3       4       other		
Elevated liver function tests (ALT/AST) for > 6 months (provide laboratory report)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Normal ALT/AST with liver biopsy consistent with progressive disease (provide reports)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Has member abstained from significant alcohol use or illegal drug abuse for > 6 months	<input type="checkbox"/> YES	<input type="checkbox"/> NO
HIV co-infection (provide laboratory data including CD4 counts and HIV RNA titer)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Contraindication for use of ribavirin (identify and provide documentation)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Pregnant or pregnant partner	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Decompensated liver disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
History of previous therapy (provide documentation of regimen and response)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>Extension of Therapy (refer to maximum duration of therapy below)</b>		
Undetectable hepatitis C PCR level at week 12 (provide laboratory report)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Hepatitis C PCR level reduced by ≥ 2 log at week 12 (provide laboratory report)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
➤ Undetectable hepatitis C PCR level at week 24 (provide laboratory report)	<input type="checkbox"/> YES	<input type="checkbox"/> NO

**Monitoring and Duration of Therapy**  
 The maximum duration of therapy is determined by genotype and co-infected status. Treatment is limited to the following durations of therapy:  
 a. genotype 1 or 4 and not co-infected with HIV: 48 weeks  
 b. genotype 2 or 3 and not co-infected with HIV: 24 weeks  
 c. co-infected with HIV and all genotypes: 48 weeks  
 Members with genotype 1 or 4, or have a contraindication for use of ribavirin:  
 a. obtain coverage review at 12 weeks for an additional 12 to 36-week extension if HCV RNA is undetectable or reduced by at least 2 log<sub>10</sub>  
 b. those members who achieve an EVR but are still HCV RNA positive at 12 weeks should be re-tested for HCV RNA at 24 weeks  
 Treatment is limited to one (1) pegylated interferon treatment course per lifetime.

**PLEASE NOTE:** ALL CHART NOTES/LAB REPORTS IN REFERENCE TO THIS REQUEST MUST BE RECEIVED BEFORE A REVIEW CAN BEGIN. REQUESTS SUBMITTED WITHOUT THIS DOCUMENTATION MAY BE DENIED.

Refer to the MVP Formulary at [www.mvphealthcare.com](http://www.mvphealthcare.com) for those drugs that require prior authorization or are subject to quantity limits or step therapy.

**FAX THIS REQUEST TO:**  
 Commercial **1-800-376-6373**  
 (HMO, EPO/PPO, Option Child, Healthy NY, Personal Plan, CompCare, ASO)

Medicare Part D **1-800-401-0915**  
 (Preferred Gold, GoldAnywhere, GoldValue, USA Care, MVP RxCare)