Physician Request Form for Hepatitis C Therapies
Fax to Pharmacy Services at 1-855-829-2872, or call 1-855-251-0966
to speak to a representative. ***Form must be completed for processing***.

AmeriHealth Caritas Delaware

Patient name:_____ Patient ID: _____
Patient address: _____ Date of Birth: _____
City: _____ State: _____ Zip: _____ Weight: _____
Prescriber name: _____ NPI: _____
Prescriber address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Fax: _____
Contact name: _____
Requested Medication name, strength, directions and duration: _____

****Please note: Preferred sofosbuvir/velpatasvir and ribavirin products do not require prior authorization for up to 12 weeks of therapy per year. Mavyret does not require prior authorization for up to 16 weeks of therapy per year****

Provider attests to all of the following:

- The member has received a complete Hepatitis B immunization series ☐Yes ☐No*
  *If No, the member has had a Hepatitis B screening (sAb, sAg and cAb) ☐Yes ☐No ☐N/A
  - If hepatitis B sAg positive the member has had a quantitative HBV DNA ☐Yes ☐No ☐N/A
    - If there is detectable HBV DNA there is a treatment plan consistent with AASLD recommendations ☐Yes ☐No ☐N/A
  - If negative for hepatitis B sAb there is a hepatitis B immunization plan or counseling to receive the hepatitis B immunization series ☐Yes ☐No ☐N/A
- The member has been screened for human immunodeficiency virus (HIV) and confirmatory testing as applicable: ☐Yes ☐No
  - If the member is confirmed positive for HIV are they being treated with antiretroviral therapy? ☐Yes ☐No* ☐N/A
    - If no, please provide the reason they are not being treated: _____
- All potential drug interactions with concomitant medications have been addressed: ☐Yes ☐No
- If the member is actively abusing alcohol or IV drugs or has a history of abuse has the member been counseled regarding the risks of alcohol or IV drug abuse and has an offer of referral for substance abuse disorder treatment been made? ☐Yes ☐No ☐N/A
- The member is committed to the treatment plan, including lab monitoring and SVR12 lab testing will be completed and submitted to health plan: ☐Yes ☐No
- Please provide the member's previous hepatitis C treatment history and response:
  _____
- The member completed hepatitis C treatment: ☐Yes ☐No
- Fibrosis Level: _____
- Is the member cirrhotic? ☐Yes* ☐No *If yes, provide Child Turcotte Pugh Class: ☐Class A ☐Class B ☐ Class C

Lab testing required (<u>attach copy of results/MUST be submitted with request</u>):

- **Genotype** (with subtype if provided): _____
- **RASs testing as indicated in guidelines** (resistance-associated substitutions, previously called RAVs)
- **Detectable HCV RNA viral load**
- **Pregnancy test** (**<u>within 1 month and ONLY if regimen contains ribavirin and the member is of child bearing age</u>**)
- **CBC (only if regimen contains ribavirin)**
- **TSH (only if regimen contains interferon)**

- If request is for a non-preferred agent, documentation of medical necessity has been provided including the medical reason the member is not able to use a preferred agent: _____
- Is the request for preferred sofosbuvir/velpatasvir or a ribavirin product for more than 12 weeks of therapy within a year or for Mavyret for more than 16 weeks of therapy within a year? ☐Yes ☐No
  - If yes, please provide documentation of medical necessity including a medical reason why treatment beyond that duration is required: _____

_____

Prescriber Signature: _____ **Print Name:** _____ **Date**: _____

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