magnolia health

envolve Pharmacy Solutions

HEPATITIS C CRITERIA/ADDITIONAL DOCUMENTATION

FAX this completed form to (855) 678-6976

OR Mail requests to: Envolve Pharmacy Solutions PA Dept.
5 River Park Place East, Suite 210 | Fresno, CA 93720

BENEFICIARY INFORMATION	
Beneficiary ID:___ ___ ___ - ___ ___ ___ - ___ ___ ___	**DOB:**___ ___ /___ ___ /___ ___ ___ ___
Beneficiary Full Name:	

Hepatitis C Therapy PA Request

Diagnosis / Treatment Status ***(check all that apply)***
***See Hepatitis-C PA instruction sheet below for approval criteria and intolerance definitions.**

□ Prescriber is, or has consulted with a gastroenterologist, hepatologist, ID specialist or other Hepatic specialist. Requires consult within the past year with documentation of recommended regimen.
□ Active HCV infection verified by viral load within the last year: HCV RNA: _____ million IU/mL Date:_____
Genotype verified by lab: □ 1a □ 1b □ 2 □ 3 □ 4 □ 5 □ 6

Patient is:
□ Treatment naïve □ Relapser
□ Prior partial responder □ Prior null responder
□ Stopped prior therapy for other reason:
_____
HIV status: □ positive □ negative □ unknown
□ Patient has not taken amiodarone within 535 days (required if regimen includes Harvoni or Sovaldi)
□ RBV-Ineligible* *Ineligibility reason: _____
Hepatic fibrosis stage ___ Last stage evaluation date: _____Method of cirrhosis/fibrosis stage:_____

□ Decompensated cirrhosis
□ Compensated cirrhosis Child-Pugh Score: _____
□ Post-liver transplant
□ Hepatocellular carcinoma and awaiting a liver transplant: Transplant date: _____
□ Not yet scheduled
□ Dialysis _Yes/___No
□ CrCl ___ mL/min Lab Date w/n last year:_____
□ Screened for HEP-B w/in last 3 mo and tx considered per AASLD/IDSA guidelines.

Prior HCV Treatment: last two regimens, if any
Regimen: _____ Dates/duration of use: _____ Response: _____
Regimen: _____ Dates/duration of use: _____ Response: _____

Social History ***(check all that apply)***

□ Patient is 18 years old or older

Documentation (available if requested) of:

□ Counseling regarding abstinence from alcohol, IV drug use and education on how to prevent HCV transmission.
□ Abstinence from drugs and alcohol for at least 6 months; negative urine drug screen required if there is IV drug use history.

For women of childbearing potential and male patients with female partners of childbearing potential ***(for RBV regimens only)*****:**

□ Patient is not pregnant (or a male with a pregnant female partner) and not planning to become pregnant during treatment or within 6 months of stopping treatment.
□ Agreement that partners will use two forms of effective contraception during treatment and for at least 6 months after stopping treatment.
□ Verification that monthly pregnancy tests will be performed throughout treatment.

Regimen Requested* ***See Hepatitis-C PA instruction sheet below for drug regimens and intolerance definitions.**

Regimens using preferred drugs:
□ Harvoni for _____ weeks
□ Harvoni + RBV for _____ weeks
□ Sovaldi + RBV for _____ weeks
□ Epclusa for _____ weeks
□ Epclusa + RBV for _____ weeks

□ Viekira Pak® + RBV or Viekira XR + RBV for _____weeks
□ Viekira Pak or Viekira XR for _____weeks
□ Technivie + RBV for _____ weeks
□ Zepatier for _____ weeks
□ Zepatier + RBV for _____ weeks

□ OTHER drugs/treatment duration: _____
Please provide clinical rationale for choosing a regimen beyond current guidelines guidance, or for selecting regimens using non-preferred drugs.

Prescription Information

Drug name / strength	Frequency / instructions	Quantity	Refills

SUBMISSION AND/OR APPROVAL OF A DRUG PRIOR AUTHORIZATION REQUEST DOES NOT GUARANTEE MEDICAID PAYMENT FOR PHARMACY PRODUCTS OR THE AMOUNT OF PAYMENT. ELIGIBILITY FOR AND PAYMENT OF MEDICAID SERVICES ARE SUBJECT TO ALL TERMS AND CONDITIONS AND LIMITATIONS OF THE MEDICAID PROGRAM.
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