WellSense HEALTH PLAN

Phone: 877-417-0528 (Clarity plans)
Fax: 833-951-1680

MASSACHUSETTS STANDARD FORM FOR HEPATITIS C MEDICATION PRIOR AUTHORIZATION REQUESTS

**Some plans might not accept this form for Medicare or Medicaid requests.*

A. Destination	
Health Plan or Prescription Plan Name:	
Health Plan Phone:	Health Plan Fax:

B. Patient Information		
Patient Name:	DOB:	Member ID #
Sex assigned at birth: ☐ Male ☐ Female ☐ "X" or Intersex		
Current Gender: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Other		

Plans do not discriminate based on race, color, national origin, age, disability, religion, creed, sexual orientation, or sex (including gender identity and gender stereotyping).

C. Prescriber Information	
Prescribing Clinician:	Phone #:
Specialty:	Secure Fax #:
NPI #:	DEA #:
Prescriber Point of Contact Name (POC) (if different than prescriber):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
Prescribing Clinician or Authorized Representative Signature:	
Date:	

D. Medication Information

Check if Expedited Review/Urgent Request:

☐ (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request as defined by the carrier.)

☐ Daklinza ☐ Epclusa ☐ Harvoni ☐ Olysio ☐ Ribavirin Generic ☐ Ribavirin Branded
☐ Sovaldi ☐ Technivie ☐ Viekira Pak ☐ Viekira XR ☐ Zepatier ☐ Vosevi ☐ Mavyret ☐ Other_____

Requested Duration of Treatment: _____ weeks

Type of Therapy: ☐ Initial ☐ Continuation — weeks remaining: _____

Anticipated or actual start date:

Is the medication prescribed by, or in consultation with, a gastroenterologist, infectious disease specialist, or hepatologist? ☐ Yes ☐ No

For Zepatier only: Has there been confirmation that the patient does not have a genotype 1a with a baseline NS5A polymorphism?
☐ Yes ☐ No ☐ Unknown

For Ribavirin only: Does the patient require a dosage form other than generic ribavirin 200 mg capsules or tablets? ☐ Yes ☐ No If yes, please specify the following:

Dosage form requested: _____

Clinical reason for use: _____

Are any of the following statements true?

☐ Patient is pregnant or plans to become pregnant within 6 months of completing treatment

☐ Patient is male with a female partner who is pregnant or plans to become pregnant within 6 months of completing treatment

☐ Patient has contraindications or intolerance to Ribavirin

E. Patient Clinical Information

Please refer to plan-specific criteria for details related to required information.

Diagnosis: ☐ B18.2 Hepatitis C (chronic) ☐ Other: _____

HCV Genotype: ☐ 1 ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

Stage of Hepatic Fibrosis: ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4

If F4: ☐ Compensated ☐ Decompensated

Check all methods of assessment that apply and include result:

Method	Result
☐ Liver biopsy	See above
☐ Transient elastography (FibroScan)	_____ kPa
☐ Shear wave elastography	_____ kPa
☐ MRE	_____ kPa
☐ FibroSure (FibroTest)	_____
☐ Echosens Fibrometer	_____
☐ Fibrospect	_____
☐ APRI	_____
☐ Fib-4	_____
☐ Hepascore	_____
☐ Other: _____	_____

Does the patient have HIV coinfection? ☐ Yes ☐ No ☐ Unknown

Is the patient status post liver transplant? ☐ Yes ☐ No

Confirm the patient's GFR range: ☐ 0–14 ☐ 15–29 ☐ 30 or greater *(Please specify.)* _____

HCV RNA levels:

Baseline (most recent): _____ IU/mL Date of lab work: _____

Week 8 of treatment (if continuation request): _____ IU/mL Date of lab work: _____

Previous Treatments

Has the patient been previously treated for Hepatitis C and failed treatment? ☐ Yes ☐ No

Adverse Reaction? ☐ Yes ☐ No

Drug Name	Date of treatment (MM/YY)	Response to treatment
		☐ Relapsed ☐ Partial response ☐ Null response (<2 log reduction in HCV RNA at Week 12) ☐ Did not complete ☐ Briefly describe details: _____
		☐ Relapsed ☐ Partial response ☐ Null response (<2 log reduction in HCV RNA at Week 12) ☐ Did not complete ☐ Briefly describe details: _____
		☐ Relapsed ☐ Partial response ☐ Null response (<2 log reduction in HCV RNA at Week 12) ☐ Did not complete ☐ Briefly describe details: _____

Additional information pertinent to this request:

F. Exceptions to Step Therapy

Please complete the applicable section(s).

Is the alternative drug required under the step therapy protocol contraindicated, or will likely cause an adverse reaction in, or physical or mental harm to the member? ☐ Yes ☐ No

If yes, briefly describe details of contraindication, adverse reaction, or harm:

Is the alternative drug required under the step therapy protocol expected to be ineffective based on the known clinical characteristics of the member and the known characteristics of the alternative drug regiment? ☐ Yes ☐ No

If yes, briefly describe details of known clinical characteristics of member and alternative drug regimen.

Has the member previously tried the alternative drug required under the step therapy protocol, or another alternative drug in the same pharmacologic class or with the same mechanism of action, and such alternative drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No

If yes, please provide details for the previous trial:

Drug Name: **Dates/duration of use:**

Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response

Briefly describe details of adverse reaction or inadequate response:

Drug Name: **Dates/duration of use:**

Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response

Briefly describe details of adverse reaction or inadequate response:

Is the member stable on the requested prescription drug prescribed by the health care provider, and switching drugs will likely cause an adverse reaction in or physical or mental harm to the member? ☐ Yes ☐ No

If yes, briefly provide details on the member's stability and the likely adverse reaction or physical or mental harm:

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.