reliance|rx℠
15 Earhart Drive, Suite 101, Amherst, NY 14221

HEPATITIS C AUTHORIZATION AND RE-AUTHORIZATION REQUEST

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Member Name:	Today's Date:
Date of birth: Sex: Weight:	Prescriber: Hospital/Clinic:
Home Phone Number: ( )	Phone Number: Fax Number: ( )
Home Address:	Address:
Payor: ☐Independent Health ☐Anne Arundel Health System ☐Pharmacy Benefit Dimensions ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Self-funded	Notes :
Insurance ID: Group Number:	Allergies:

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: _____

ICD10 Code: _____

Genotype: _____

HCV-RNA: _____ Date: _____

HBsAG: _____ Date: _____

Anti-HBc: _____ Date: _____

Please include a list of failed therapies: _____

_____

_____

Please indicate if request is for brand or generic medication:

_____

☐ If patient is co-infected with HCV/HBV, documentation has been submitted that they will be monitored for HBV reactivation and Hepatitis flare during HCV treatment and post treatment follow up. Initiate appropriate patient management for HBV infections

AND

-Patient liver cirrhosis status _____

AND

-Documentation of patient's CHC treatment status _____

_____

AND

-If patient was treated for Hepatitis C previously, submit documentation of patient's response to therapy/ confirmation of patient adherence.

AND

☐Patient verbally or in writing commits to compliance with documented planned course of treatment *(ie, blood tests, visits during/after treatment)*

AND

☐ Certification by provider that patient has demonstrated treatment readiness using one of the drug and alcohol use scales or assessments provided by SAMHSA-HRSA or Psychological Readiness Evaluation and Preparation for Hepatitis C Treatment (PREP-C) tool.

- Provider may not certify to patient readiness in instances of re-infection after a prior successful treatment regimen.

DRUG SELECTION CONTINUED

☐ **Epclusa** **Dose/Frequency**:_____

Baseline ALT Value:_____ Date: _____

☐ Patient is sofosbuvir naïve

☐ Patient is velpatasvir naïve

☐ **Harvoni** **Dose/Frequency**:_____

Baseline ALT Value:_____ Date: _____

☐ Patient is sofosbuvir naïve

☐ Patient is ledipasiv naïve

☐ **Mavyret** **Dose/Frequency**:_____

☐ Patient is glecaprevir naïve

☐ Patient is pibrentasvir naïve

- Please submit patient's Child-Pugh status or Fibrosis score

☐ **Sovaldi** **Dose/Frequency**:_____

Baseline ALT Value:_____ Date: _____

Baseline SCr:_____ Date: _____

☐ Patient is sofosbuvir naïve

Patient will receive concurrent peginterferon alfa and/or ribavirin based on clinical course, genotype, and whether or not patient is eligible to receive interferon-based regimen ☐ YES ☐ NO

- Liver transplant status: _____

AND

- Submission of documentation the member is without decompensated liver disease (Child Pugh Class B or C)

AND

- Submission of negative pregnancy test result for female patients of reproductive potential before starting treatment and confirmation this test will be performed every month on therapy and for six months after treatment ends.

☐ **Vosevi** **Dose/Frequency**:_____

Baseline ALT Value:_____ Date: _____

☐ **Zepatier** **Dose/Frequency**:_____

(Please list all failed formulary alternatives or contraindications for formulary alternatives for genotype)

Baseline ALT Value:_____ Date: _____

- Submission of documentation that patient is without moderate or severe hepatic impairment (Child-Pugh B or C)
- If genotype 1a, submission of NS5A resistance-associated polymorphisms test results