PRIOR AUTHORIZATION REQUEST FORM

Virginia Premier Hepatitis C Non-Preferred Review

Phone: 800-727-7536 Fax back to: 833-770-7569

Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Please provide the patient's anticipated duration of therapy below:

Q2. Is the requested medication prescribed by or in consultation with a gastroenterologist, hepatologist, transplant specialist, or infectious disease specialist?

☐ Yes ☐ No

Q3. Does the patient have a diagnosis of chronic hepatitis C?

☐ Yes ☐ No

Q4. Does the patient have compensated cirrhosis?

☐ Yes ☐ No

Q5. Does the patient have hepatocellular carcinoma?

☐ Yes ☐ No

Q6. Does the patient have decompensated cirrhosis (Child-Pugh Class B or C)?

PRIOR AUTHORIZATION REQUEST FORM

Virginia Premier Hepatitis C Non-Preferred Review

Phone: 800-727-7536 Fax back to: 833-770-7569

Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q7. IF YES, then does the patient have a Child Pugh score greater than 6?	
☐ Yes	☐ No
Q8. Is the patient status post-liver transplant?	
☐ Yes	☐ No
Q9. Does the patient have end stage renal disease?	
☐ Yes	☐ No
Q10. IF YES, then does the patient require hemodialysis?	
☐ Yes	☐ No
Q11. Does the patient have a history of severe renal impairment (estimated GFR of less than 30 mL/min/1.73m2)?	
☐ Yes	☐ No
Q12. Does the patient have HCV genotype 1 with or without polymorphism?	
☐ Yes	☐ No
Q13. Does the patient have HCV genotype 2?	
☐ Yes	☐ No
Q14. Does the patient have HCV genotype 3?	
☐ Yes	☐ No
Q15. Does the patient have HCV genotype 4?	
☐ Yes	☐ No
Q16. Does the patient have HCV genotype 5?	
☐ Yes	☐ No
Q17. Does the patient have HCV genotype 6?	
☐ Yes	☐ No

PRIOR AUTHORIZATION REQUEST FORM

Virginia Premier Hepatitis C Non-Preferred Review

Phone: 800-727-7536 Fax back to: 833-770-7569

Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**

Prescriber Signature

Date