

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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q3. Does the patient have a diagnosis of chronic hepatitis C? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q4. Does the patient have compensated cirrhosis? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q5. Does the patient have hepatocellular carcinoma? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Does the patient have decompensated cirrhosis (Child-Pugh Class B or C)?

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

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Patient Name:	Prescriber Name:
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Prescriber Signature

Date

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