PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Virginia Premier Hep C Non-Preferred Review

Phone:
Medallion 855-872-0005 **Fax back to: 866-754-9616**
VPEPLUS 844-838-0711

EnvisionRx manages the pharmacy drug benefit for your patient. 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 indicate prescriber's specialty or if prescribed in consultation with one of the following:

- ☐ Gastroenterologist
- ☐ Hepatologist
- ☐ Transplant specialist
- ☐ Infectious Disease
- ☐ None of the above

Q2. Please indicate the member's diagnosis:

- ☐ Chronic Hepatitis C
- ☐ Compensated cirrhosis
- ☐ Hepatocellular carcinoma
- ☐ Decompensated cirrhosis (Child-Pugh score class B or C)
- ☐ Status post liver transplant
- ☐ None of the above

Q3. Please indicate member's HCV genotype

- ☐ 1a (polymorphism)
- ☐ 1b
- ☐ 2
- ☐ 3

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Virginia Premier Hep C Non-Preferred Review

Phone:
Medallion 855-872-0005 **Fax back to: 866-754-9616**
VPEPLUS 844-838-0711

EnvisionRx manages the pharmacy drug benefit for your patient. 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:**

☐ 4
☐ 5
☐ 6

Q4. Does patient have 1a with polymorphism?

☐ Yes ☐ No

Q5. If yes, please submit test results. Will results be submitted with request?

☐ Yes ☐ No

Q6. Has the prescriber assessed the member for adherence with medical and pharmacological treatment?

☐ Yes ☐ No

Q7. Has the prescriber evaluated the member for current substance use disorder including alcohol use disorder? (•Members identified with a substance use disorder should be referred for treatment, • Member cannot be denied Hepatitis C treatment for sole reason of substance abuse, • Testing for illicit drug and/or alcohol use is not required)

☐ Yes ☐ No

Q8. Does patient have decompensated cirrhosis (Child-Pugh score greater than 6 [Class B or C])?

☐ Yes ☐ No

Q9. Does patient have a history of severe renal impairment (eGFR <30 mL/min/1.73m2) or end stage renal disease requiring hemodialysis?

☐ Yes ☐ No

Q10. If yes to question 9 or 10, please provide details:

Q11. Please indicate if the member has had a previous trial and failure to any of the following:

☐ Daklinza
☐ Epclusa
☐ Harvoni
☐ Interferon
☐ Ledipasvir-sofosbuvir
☐ Peginterferon
☐ Ribavirin
☐ Sofosbuvir/Velpatasvir
☐ Sovaldi
☐ Viekira Pak/XR
☐ Zepatier
☐ Vosevi
☐ None of the above

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Virginia Premier Hep C Non-Preferred Review

Phone:
Medallion 855-872-0005 **Fax back to: 866-754-9616**
VPEPLUS 844-838-0711

EnvisionRx manages the pharmacy drug benefit for your patient. 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