UnitedHealthcare Community Plan

Non-Preferred Hepatitis C Medications – Virginia
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Member Information			Prescriber Information		
Member Name:			Provider Name:		
Member ID:			NPI #:	Specialty:	
Date Of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP Code:	Office Street Address:		
Phone:	Allergies:		City:	State:	ZIP Code:

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____
Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____
Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Medication Information

Medication:	**Strength:**
Directions for use (Include length of therapy):	**Quantity:**

Medication Administered: ☐ Self-Administered ☐ Physician's Office ☐ Other: _____

Clinical Information

What is the patient's diagnosis for the medication being requested? _____
_____

ICD-10 Code(s): _____

Are there any supporting laboratory or test results related to the patient's diagnosis*? (Please specify or provide documentation)*

Previous Medication Trials / Contraindications

Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

What medication(s) does the patient have a history of failure to? *(Please specify ALL medication(s)/strengths tried, directions, length of trial, and reason for discontinuation of each medication)*

What medication(s) does the patient have a contraindication or intolerance to? *(Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)*

Additional information that may be important for this review

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Patient First name:	Patient Last name:	Patient DOB:

Clinical and Drug Specific Information

ALL REQUESTS

What is the patient's hepatitis C virus (HCV) genotype? _____
DOCUMENTATION MUST BE SUBMITTED

□ **Yes** □ **No**	**Has the provider <u>assessed</u> the patient for ALL of the following?** • Acute or Chronic hepatitis C • Compensated cirrhosis • Decompensated cirrhosis • Hepatocellular carcinoma • Status post liver transplant
□ **Yes** □ **No**	**Has the patient been <u>evaluated</u> for BOTH of the following?** • Severe renal impairment (eGFR < 30 ml/min/1.73m2) • End stage renal disease (ESRD) requiring hemodialysis
□ **Yes** □ **No**	**Does the patient have decompensated cirrhosis (Child-Pugh score greater than 6 [class B or C])?**
□ **Yes** □ **No**	**Is the requested medication or regimen being prescribed by, or in consultation with, a gastroenterologist, hepatologist, infectious disease specialist or transplant specialist?**
□ **Yes** □ **No**	**Has the patient had a therapeutic failure with ONE of the following preferred drugs within the same class?** *(If yes, check which applies and complete "Previous Medication Trials/Contraindications" section on first page)* □ Mavyret □ Sofosbuvir-velpatasvir (authorized generic of Epclusa)
□ **Yes** □ **No**	**If no to the above question, is there a clinical reason why the patient cannot be changed to a preferred drug within the same class [Mavyret or sofosbuvir-velpatasvir (authorized generic of Epclusa)] (e.g., allergy, contraindication, history of side effects)?** *If yes, document reason:*

PEGASYS

□ **Yes** □ **No**	**Has the patient had a therapeutic failure with the preferred drug within the same class (Peg-Intron)?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ **Yes** □ **No**	**If no to the above question, is there a clinical reason why the patient cannot be changed to the preferred drug within the same class (Peg-Intron) (e.g., allergy, contraindication, history of side effects)?** *If yes, document reason:*

Provider Signature: _____ **Date:** _____