Pharmacy Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Hepatitis C Medications

This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois Medicaid at **1-844-242-0908**. Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Hepatitis C Medications. Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Prior authorization for hepatitis C treatment requires submission of medical records with the prior authorization request. *Incomplete and/or illegible request forms may result in a denial including those without medical records.*

- Zepatier
- Epclusa
- Harvoni
- Sovaldi
- Daklinza
- Viekira Pak/Viekira XR
- Mavyret
- Technivie
- Olysio
- Pegasys/Peg-Intron
- Ribavirin
- Vosevi

Patient Information		Provider Information		
Patient Name:		Prescriber Name: NPI#:		
Member ID#:	DOB:	Address	City	State
		Zip:		
Patient Phone #:		Office Phone: Office Fax#:		
		Prescriber's Email:		

Requested Treatment Regimen (Check all medications requested):

☐ Zepatier	☐ Epclusa	☐ Harvoni
☐ Sovaldi	☐ Viekira Pak/XR	☐ Olysio
☐ Daklinza	☐ Technivie	☐ Mavyret
☐ Ribavirin/Ribasphere	☐ Vosevi	☐ Pegasys

Treatment Duration:

☐ 8 weeks ☐12 weeks ☐16 weeks ☐ 24 weeks ☐Other _____(please specify)

Criteria for Approval

Decisions are based on the criteria established by Aetna Better Health of Illinois which may be found at: https://www.aetnabetterhealth.com/illinois/providers/fhp/pharmacy

Please answer all required questions below **and** provide relevant supporting information including medical records.

1.	**Is this a request to continue a previously approved treatment (i.e., previous authorization is on file under this plan)?**	☐ Yes ☐ No

2.	**Does the patient meet ALL of the following criteria?** a. Diagnosis of Hepatitis C with a genotype 1-6 confirmed by detectable serum HCV RNA by quantitative assay completed within the last 90 days b. Member understands treatment regimen and agrees to remain compliant during the full course of therapy	☐ Yes ☐ No
3.	**Is the treatment prescribed by a specialist in gastroenterology, hepatology, HIV, or infectious disease, or transplant?**	☐ Yes ☐ No
4.	**Does the prescriber agree with monitoring treatment plan to submit HCV-RNA levels at treatment week 4 and 3 months post treatment (SVR12)?**	☐ Yes ☐ No
5.	**Does the patient have ANY of the following treatment exclusions?** a. Contraindications to any of the agents b. Use in combination with other DAA's unless indicated c. Lifetime expectancy of less than 12 months due to non-liver related condition	☐ Yes ☐ No
6.	**Has the patient been screened for Hepatitis B within the previous year?**	☐ Yes ☐ No
7.	**For HBV negative patients: If not previously vaccinated, has vaccination been initiated or is there a plan to initiate (if not contraindicated)?**	☐ Yes ☐ No
8.	**For HBV positive patients or history of HBV positive patients: Will the patient be placed on suppressive therapy or monitored for reactivations, as appropriate?**	☐ Yes ☐ No
9.	**Has the prescriber provided counseling regarding the risks of alcohol or IV drug abuse and offered a referral for substance use disorder treatment when history of abuse is present?**	☐ Yes ☐ No

The patient's treatment status:

Treatment Naïve ☐ Treatment Experienced ☐ Status Post Transplant ☐

Prior Hepatitis C Treatments (check all applicable):

Incivek ☐ Victrelis ☐ Olysio☐ peginterferon☐ ribavirin ☐ Sovaldi☐ Harvoni ☐ Viekira Pak☐

Daklinza ☐ Technivie ☐ Epclusa ☐ Viekira XR☐ Zepatier ☐ Mavyret ☐ Vosevi ☐

Does the patient have EGFR < 30 ml/min or has ESRD requiring hemodialysis ☐Yes ☐ No

Is the patient pregnant, or is the male's female partner pregnant (for ribavirin regimens)? ☐Yes ☐ No

Diagnosis / Dosing (all sections required)

Diagnosis (include ICD9 Code):	**Genotype:**	**Viral Load (HCV-RNA):**
_____	1☐ 2☐ 3☐ 4☐ 5☐ 6☐ (must submit lab results completed within 90 days of treatment initiation) NS5A polymorphism: 28 ☐ 30 ☐ 31☐ 93☐	Treatment Week 4: Treatment Week 12: Treatment Week 24:

Please indicate fibrosis level (required) and submit supporting documentation with request:
F1 ☐ F2 ☐ F3 ☐ F4 ☐

Does the patient have cirrhosis?
Yes ☐ No ☐

If Yes, please indicate the Child-Pugh Score:
CPT A ☐ CPT B ☐ CPT C ☐

Does the patient have hepatocellular carcinoma meeting Milan criteria (awaiting liver transplantation)?
Yes ☐ No ☐

If Yes, please provide the potential transplant date:

Approved Treatment Regimens and Durations – Please select one regimen below

Select	Diagnosis	Treatment Regimen	Regimen Duration
☐	Genotypes 1, 2, 3, 4, 5, or 6 Treatment Naïve and no cirrhosis	Mavyret	8 weeks
☐	Genotypes 1, 2, 3, 4, 5, or 6 Treatment Naïve with compensated cirrhosis (Child-Pugh A)	Mavyret	12 weeks
☐	Genotype 1 Treatment Experienced with an NS5A inhibitor[1] without an NS3/4A protease inhibitor (PI) No cirrhosis or with compensated cirrhosis (Child-Pugh A)	Mavyret	16 weeks
☐	Genotype 1 Treatment Experienced with an NS3/4A PI without an NS5A inhibitor No cirrhosis or with compensated cirrhosis (Child-Pugh A)	Mavyret	12 weeks
☐	Genotype 1, 2, 4, 5, or 6 Treatment Experienced with PRS No cirrhosis	Mavyret	8 weeks
☐	Genotype 1, 2, 4, 5, or 6 Treatment Experienced with PRS with compensated cirrhosis (Child-Pugh A)	Mavyret	12 weeks
☐	Genotype 3 Treatment Experienced with PRS no cirrhosis or with compensated cirrhosis (Child-Pugh A)	Mavyret	16 weeks

☐	OTHER (please specify):	OTHER (please specify):	OTHER (please specify):

Additional Information:

By signing, the prescribing or authorizing clinician is attesting that the information on this form is accurate as of this date and that documentation supporting the above information is recorded in the patient's medical chart. Requests for Hepatitis C medications must be submitted with supporting medical records.

_____ _____

Prescriber (Or Authorized) Signature **Date**