09/25/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS FAMILY HEALTH PLAN (MEDICAID)
Victrelis (IL88)
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 Victrelis (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Victrelis (boceprevir)

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Has Aetna Better Health authorized this medication in the past for this patient (i.e., previous authorization is on file under Aetna Better Health)? Y N

   [If yes, skip to question 5: REAUTHORIZATION REQUESTS]

2. INITIAL AUTHORIZATION REQUESTS: Does the patient meet all of the following? Please document prescriber specialty and patient treatment type (treatment naïve, previous relapser, partial responder, or null responder): Y N

   Patient is 18 years of age, or older \ Diagnosis is chronic hepatitis C (HCV) genotype 1 infection \ Victrelis will be used in combination with peg-interferon and ribavirin. Note: If peginterferon alfa or ribavirin is discontinued for any reason, Victrelis must also be discontinued. \ Patient treatment type is documented (treatment naïve, previous relapser, partial responder, null responder). \ Therapy is prescribed by, or in consultation with a gastroenterologist, hepatologist or infectious diseases specialist [If no, skip to question 6.]

   [If no, no further questions.]

3. Does the patient have any of the following? If yes, please document Y N

   HIV coinfection \ Hepatitis B coinfection \ Organ transplant recipient \ Decompensated liver disease \ Previous null-responder (Note: Victrelis/boceprevir has not been studied and is not indicated for previous null responders)

   [If yes, no further questions.]

4. Will the patient's HCV-RNA level be assessed at treatment week 8 (TW8), treatment week 12 (TW12), and treatment week 24 (TW24)? Y N

   [No further questions.]

5. REAUTHORIZATION REQUESTS: Has the patient completed at least 8 weeks* of therapy? Please document actual treatment start date Y N

   (*4 weeks of lead-in treatment with peg-interferon +ribavirin, followed by 4 weeks of triple therapy with Victrelis)

   [If no, no further questions.]

6. Have the treatment week 8 (TW8)* HCV-RNA levels been drawn? Please document HCV-RNA and date drawn Y N

   (*4 weeks of lead-in treatment with peg-interferon +ribavirin, followed by 4 weeks of triple therapy with Victrelis)

   [If no, no further questions.]

7. Has the patient completed greater than 12 weeks* of therapy? Y N

   (*4 weeks of lead-in treatment with peg-interferon +ribavirin, followed by 8 weeks of triple therapy with Victrelis)

   [If no, no further questions.]

8. Have the treatment week 12 (TW12) HCV-RNA levels been drawn? Y N

   [If no, no further questions.]

9. Is the patient's treatment week 12 (TW12) HCV-RNA level either undetectable or less than 100 IU/ml? Please document HCV-RNA and date drawn: Y N

   [If no, no further questions.]

10. Has the patient completed at least 24 weeks of therapy? Y N

    (*4 weeks of lead-in treatment with peg-interferon +ribavirin, followed by 20 weeks of triple therapy with Victrelis)

    [If no, no further questions.]

11. Is the patient's treatment week 24 (TW24) HCV-RNA level undetectable? Please document HCV-RNA and date drawn: Y N

    [If no, no further questions.]

12. Does the patient meet one of the following? Y N

    Patient has cirrhosis, OR \ Patient is a previous null responder.

    [If yes, no further questions.]

13. Is patient treatment naïve? Y N

[If yes, skip to question 15.]

14. Is patient a previous partial responder or relapser? Y N

[No further questions.]

15. Were HCV-RNA levels at treatment week 8 (TW8) undetectable? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date