MOLINA HEALTHCARE OF ILLINOIS
Phone: (855) 866-5462 | Fax: (855) 365-8112

Medications for Treatment of Chronic Hepatitis C
Prior Authorization Request Form

All information on this form must be completed legibly with relevant clinical documentation for timely review. Incomplete forms or failure to submit required supporting documentation will delay the review process. Prior authorizations will be approved for 8 weeks at a time. A new form must be submitted every 8 weeks. If member meets all criteria and approval for therapy is granted, medication will be dispensed by a specialty pharmacy vendor at the discretion of Molina Healthcare.

MEMBER INFORMATION:			
MEMBER NAME: (LAST, FIRST, MIDDLE INITIAL)			
MEMBER ID NUMBER:	DATE OF BIRTH: ____/____/____	GENDER:	
CURRENT ADDRESS:	CITY:	STATE:	ZIP:
WEIGHT: _____ kg / lbs	ETHNICITY:		

PRESCRIBER INFORMATION:			
PRESCRIBER NAME: (LAST, FIRST)	PRESCRIBER SPECIALTY:	10-DIGIT NPI NUMBER:	
OFFICE CONTACT NAME:	PHONE NUMBER: (____)	FAX NUMBER: (____)	
ADDRESS:	CITY:	STATE:	ZIP:

MEDICATION INFORMATION:		
☐ Initial therapy request	☐ Re-authorization request Date Hepatitis C medications initiated: ____/____/____ Date of last dose: ____/____/____	
MEDICATION:	STRENGTH:	DOSAGE FORM:
DIRECTIONS FOR USE:	QUANTITY:	DAYS SUPPLY:
REQUESTED TOTAL LENGTH OF THERAPY: ☐ 8 WEEKS ☐ 12 WEEKS ☐ 16 WEEKS ☐ 24 WEEKS ☐ _____		

CLINICAL INFORMATION ** Provider must submit *SUPPORTING DOCUMENTATION* and *LAB TEST RESULTS* completed within 3 months prior to this request, unless otherwise noted**.	
Diagnosis (check all that apply): ☐ Chronic Hepatitis C virus (HCV) ☐ Other_____ ICD-10 Code: _____ ☐ Compensated Cirrhosis ☐ Decompensated Cirrhosis	
HCV lab confirmed genotype (including subtype):	☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ Mixed: _____ if genotype 1a: HCV NS5A polymorphism lab: ☐ present ☐ absent
HCV RNA level (baseline quantitative viral load within 1 year):	_____ IU/ML Date of lab: ____/____/____
CLINICAL INFORMATION	

** Provider must submit *SUPPORTING DOCUMENTATION* and *LAB TEST RESULTS* completed within 3 months prior to this request, unless otherwise noted**.	
LIVER ASSESSMENT	
Metavir or equivalent Fibrosis score confirmed by ONE of the following tests: ☐ Liver biopsy: Stage: _____ Date of biopsy: ____/____/____ OR ☐ Transient elastography (FibroScan®): OR ☐ FibroSure® OR ☐ FibroTest® OR ☐ FibroMeter™ Score: _____	
LAB TESTS	
1. Liver function tests (LFTs)	☐ YES ☐ NO
2. Complete Blood Count (CBC) with white cell differential count	☐ YES ☐ NO
3. eGFR	☐ YES ☐ NO
4. Negative HBV screen (HBsAG, anti-HBs, and anti-HBc) i. If positive: provide quantitative HBV DNA and verification of treatment regimen	☐ YES ☐ NO
5. Complete this section only if stage 4 fibrosis only: Bilirubin, albumin, International normalized ratio (INR), Child-Pugh score Child Pugh Score: _____ Date: ____/____/____ ☐ Class A (5 – 6 points) ☐ Class B (7 – 9 points) ☐ Class C (10 – 15 points)	☐ YES ☐ NO
OTHER	
1. Clinic or consultation notes from specialist consultation	☐ YES ☐ NO
2. Signed patient commitment letter with treatment plan which includes: a. Anticipated dosing plan and required follow-up schedule b. Description of schedule by which patient will obtain refill prescriptions c. Information on how to reduce risk of exposure and transmission of the disease	☐ YES ☐ NO
3. Provider agrees to submit progress notes and HCV RNA levels to Molina within the first 8 weeks of therapy, 12 weeks after completion of therapy, and 24 weeks after completion of therapy, or until the viral load is undetectable	☐ YES ☐ NO
PREVIOUS HCV THERAPY	
☐ Hepatitis C treatment naïve:	☐ Hepatitis C treatment-experienced *if yes, list prior treatment regimen and dates below Regimen: _____ Date: _____ Weeks completed: _____ Regimen: _____ Date: _____ Weeks completed: _____
PATIENT READINESS and ADHERENCE:	
1. Prescriber confirms that in his or her opinion, the patient is: a. Able to make appropriate decisions about treatment b. Able to comply with dosing and other instructions c. Capable of completing therapy as prescribed	☐ YES ☐ NO
2. Prescriber confirms that he or she is addressing the ongoing misuse of alcohol and/or continued use of illicit IV drugs (if applicable).	☐ YES ☐ NO
3. Patient and prescriber are aware that non-adherence with regimen, or the patient's failure to obtain refills in a timely manner, may result in discontinuation of prior approval, unless the non-adherence was due to situations beyond the patient's control	☐ YES ☐ NO
4. Has patient previously discontinued hepatitis C therapy prior to completion due to non-adherence? a. If yes, has provider counseled patient on adherence?	☐ YES ☐ NO ☐ YES ☐ NO
THERAPY CONTRAINDICATIONS, COMORBIDITIES *documentation required	
1. Prescriber confirms the treatment regimen prescribed is not for an indication outside of the FDA approved labeling, and no contraindications or significant drug interactions to treatment exist as specified in the product labeling	☐ YES ☐ NO
2. Does the patient have End Stage Renal Disease requiring dialysis?	☐ YES ☐ NO
3. Does the patient have severe kidney disease with GFR <30mL/min?	☐ YES ☐ NO
4. Is the patient taking prescribed or over-the-counter medication known to be contraindicated or have serious drug interaction with above requested Hepatitis C treatment regimen?	☐ YES ☐ NO

5. Has the patient completed pre-transplant evaluation and are they currently awaiting transplant? a. If yes, provide anticipated transplant date: _____/_____/_____	☐ YES ☐ NO
6. Has the patient previously had a liver transplantation? a. If yes, provide date of transplant: _____/_____/_____	☐ YES ☐ NO
7. Complete this section only for regimens that include ribavirin: a. If patient is female and of child-bearing age, prescriber has confirmed patient is not pregnant or nursing b. If patient is male, prescriber has confirmed patient's partner is not pregnant	☐ YES ☐ NO ☐ YES ☐ NO

CONTINUATION OF THERAPY REQUESTS ***This portion is NOT required for initial therapy requests***		
Through regular office visits and monitoring of therapy, please answer and submit supporting documentation of the following: 1. Member demonstrates compliance and takes medications for chronic Hepatitis C as prescribed 2. No sign(s) of high-risk behavior (recurring alcoholism, IV drug use, etc.), unstable psychiatric conditions, or failure to complete HCV disease evaluation appointments and procedures		☐ YES ☐ NO ☐ YES ☐ NO
HCV RNA LEVEL AT THE APPROPRIATE WEEK, BASED ON CURRENT THERAPY *Submit HCV RNA viral load lab results after initiation of treatment to Molina Healthcare for review as soon as available. If failure to submit HCV RNA labs result in missed doses, continuation of treatment may not be authorized.		
Baseline RNA Level	_____IU/mL Date of Lab: ____/____/____	
Week 4 HCV RNA Level	_____IU/mL Date of Lab: ____/____/____	Achieved a 2-log decrease in viral load from baseline? ☐ YES ☐ NO
Week 12 HCV RNA Level	_____IU/mL Date of Lab: ____/____/____	HCV RNA undetectable (<25 IU/mL)? ☐ YES ☐ NO
Week 24 HCV RNA Level *if applicable	_____IU/mL Date of Lab: ____/____/____	

PRESCRIBER SIGNATURE:

☐ The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

_____ _____/_____/_____

PRESCRIBER OR AUTHORIZED SIGNATURE DATE

The material provided are guidelines used by this Molina Healthcare to authorize, modify or determine coverage for individuals with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and member's eligibility and/or benefits.