HIGHMARK HEALTH OPTIONS

Updated: 03/2022
DMMA Approved: 04/2022

Request for Prior Authorization for Hepatitis C Agents
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Hepatitis C Agents require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Hepatitis C Agents Prior Authorization Criteria:

Coverage may be provided with a diagnosis of chronic Hepatitis C Virus (HCV) Genotypes 1-6 and the following criteria is met:

- The member has a diagnosis of chronic HCV with documented genotyping
- The drug regimen is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed literature
- The requested drug regimen is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines such as the AASLD/IDSA
- The member has a Metavir fibrosis score documented by a recent noninvasive test such as a blood test or imaging, a Fibroscan or findings on physical examination.
- Documentation of detectable quantitative HCV RNA at baseline
- Documentation of previous hepatitis C treatment regimens if the member has received prior treatment(s)
- Documented results of HIV screening (HIV Ag/Ab)
- Has documentation of AASLD-recommended resistance-associated substitution (RAS) testing and is prescribed a drug regimen in accordance with AASLD guidance
- The requested Hepatitis C Agent is a preferred product and if not, documentation by the prescriber as to why the preferred product is not appropriate.
- Approval of a non-preferred agent requires:
    - A documented failure or contraindication to a preferred regimen
        - If the member has failed prior therapy, then documentation of the reason for failure is required. Simple noncompliance with previous therapy *may* be considered a contraindication to retreatment.
        - If a preferred regimen is contraindicated due to a comorbid condition, then documentation of the other condition is required.
- **Duration of Approval:** the length of the approved treatment duration.

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

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HEPATITIS C AGENTS
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon-Fri 8:00am to 7:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Health Options ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	
Planned HCV Treatment Regimen:		
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No		

Billing Information

This medication will be billed: ☐ at a specialty pharmacy OR ☐ medically, JCODE:_____
Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other:

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:
HCV Genotype:
Hepatitis C RNA Viral load: Date collected:
Metavir fibrosis Score:
Has the member received prior treatment(s) for hepatitis C? ☐ Yes, please list below ☐ No
Are there documented results of an HIV screening (HIV Ag/Ab) if appropriate? ☐ Yes, please list below ☐ No
Has documentation of AASLD-recommended resistance-associated substitution (RAS) testing been completed?
☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date