Hepatitis
Prior Authorization Request

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the prescribed regimen for patient's course of treatment? ***Indicate ALL drugs for this course of treatment.***
   ❑ Daklinza ❑ Epclusa ❑ Harvoni ❑ Olysio ❑ Pegasys ❑ Sovaldi
   ❑ Technivie ❑ Viekira Pak ❑ Viekira XR ❑ Zepatier ❑ Ribavirin ❑ Vosevi
   ❑ Other _____
2. What is the ICD-10 code? _____
3. What is the diagnosis?
   ❑ Chronic Hepatitis C
   ❑ Hepatitis B, including HDV co-infection (Pegasys only), *no further questions.*
   ❑ Chronic myeloid leukemia (CML) (Pegasys only), *no further questions.*
   ❑ Myeloproliferative neoplasm (primary myelofibrosis and post-polycythemia vera or post-essential thrombocytopenia myelofibrosis) (Pegasys only), *no further questions.*
   ❑ Other _____
4. Prior to treatment, has hepatitis C been confirmed by the presence of a viral load (HCV-RNA) in the serum?
   ❑ Yes ❑ No
5. Indicate baseline viral load (HCV-RNA) and date of lab work:
   BASELINE: _____ IU/mL Date: _____
6. Indicate patient's genotype. _____ ***If genotype 1, specify the subtype:*** ❑ 1a ❑ 1b ❑ Mixed ❑ Unknown
7. Indicate planned duration of therapy: _____ weeks
8. Indicate **SPECIFIC** date (mm/dd/yyyy) the patient will start or has started this course of therapy:
   _____ ***Do NOT indicate ASAP. If treatment will be delayed after approval, please specify.***
   If patient has started this course of treatment, indicate number of weeks: _____

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9. *If patient has genotype 1, 4, 5, or 6 infection,* the preferred product for your patient's plan is Harvoni. Can the patient's treatment be switched to Harvoni? *If Yes, skip to #14* ❑ Yes ❑ No ❑ Not applicable, *skip to #12*

10. Has the patient had an inadequate virologic response to a previous trial of Harvoni? *If Yes, skip to #14* ❑ Yes ❑ No

11. *If Viekira Pak, Viekira XR or Zepatier is being prescribed,* does the patient have end-stage renal disease (ESRD) or creatinine clearance (CrCl) of less than 30 mL/min? *If Yes, skip to #14* ❑ Yes ❑ No ❑ Not applicable

12. *If patient has genotype 2 or 3 infection,* the preferred product for your patient's plan is Epclusa. Can the patient's treatment be switched to Epclusa? *If Yes, skip to #14* ❑ Yes ❑ No

13. Has the patient had an inadequate virologic response to a previous trial of Epclusa? ❑ Yes ❑ No

14. Does the patient have any of the following conditions? ***Indicate ALL that apply or mark "None of the above."***
    - ❑ Compensated cirrhosis
    - ❑ Decompensated cirrhosis (Child Turcotte Pugh [CTP] class B or C)
    - ❑ Moderate or severe hepatic impairment (CTP class B or C)
    - ❑ Recurrent HCV infection post liver transplantation
    - ❑ Hepatocellular carcinoma
    - ❑ Awaiting liver transplantation
    - ❑ HIV co-infection
    - ❑ Documented anemia - *Indicate <u>baseline</u> hemoglobin level:* _____ g/dL
    - ❑ Documented <u>interferon</u> ineligibility - *Indicate reason:* _____
    - ❑ Ineligible to receive <u>ribavirin</u> - *Indicate reason:* _____
    - ❑ None of the above

15. What was the patient's treatment status prior to the requested regimen?

    ❑ Treatment-naive ❑ Failed prior treatment(s) - *Please indicate regimen(s) and date(s) of treatment below.*

    Regimen 1: _____

    Dates of treatment: _____

    Regimen 2: _____

    Dates of treatment: _____

    ❑ Other _____

16. Has the patient failed treatment with a HCV protease inhibitor (eg, Incivek, Olysio, Victrelis, paritaprevir) despite adequate dosing and duration of therapy? ❑ Yes ❑ No

Complete the following section based on the prescribed regimen.

<u>Section A: Harvoni +/- ribavirin</u>

17. Will Harvoni be used with other drugs containing sofobuvir, including Sovaldi? ❑ Yes ❑ No

18. Does the patient have African American ethnicity or known IL28B polymorphism CT or TT? ❑ Yes ❑ No

19. *If patient has failed previous treatment with an NS5A inhibitor,* has laboratory testing for presence of NS5A inhibitor resistance-associated variants been performed? ❑ Yes ❑ No ❑ Unknown

20. Were ledipasvir resistance-associated variants detected? ❑ Yes ❑ No

<u>Section B: Epclusa +/- ribavirin</u>

21. *If Epclusa + ribavirin is being prescribed,* did the patient fail prior treatment with a sofosbuvir- or NS5A inhibitor-containing regimen? ❑ Yes ❑ No

22. *If patient has genotype 1 or 3 and prescribed regimen is Epculsa + ribavirin,* has laboratory testing for presence of NS5A inhibitor resistance-associated variants been performed? ❑ Yes ❑ No ❑ Unknown

23. Was the Y93H variant associated with velpatasvir resistance detected? ❑ Yes ❑ No

Section C: Olysio + Pegasys + ribavirin

24. *If patient has genotype 1a,* is the NS3 Q80K polymorphism present? ❑ Yes ❑ No ❑ Unknown

25. *If patient has received 4 to 12 weeks of treatment,* specify HCV-RNA taken at 4 weeks of treatment.
Specify viral load: _____ IU/mL *Date of lab work:* _____

Section D: Sovaldi + Olysio +/- ribavirin

26. *If patient has genotype 1a,* is the NS3 Q80K polymorphism present? ❑ Yes ❑ No ❑ Unknown

27. *If patient has failed prior treatment with a NS5A inhibitor,* has laboratory testing for the presence of NS3 protease inhibitor and NS5A inhibitor resistance-associated variants been performed? ❑ Yes ❑ No ❑ Unknown

28. Were NS5A inhibitor resistance-associated variants detected? ❑ Yes ❑ No

29. Were NS3 protease inhibitor resistance-associated variants detected? ❑ Yes ❑ No

Section E: Sovaldi + ribavirin

30. Does the patient meet the MILAN criteria? ❑ Yes ❑ No
A) Tumor size 5 cm or less in diameter with single hepatocellular carcinomas OR 3 tumor nodules or less, each 3 cm or less in diameter with multiple tumors **AND**
B) No extrahepatic manifestations of the cancer or evidence of vascular invasion of tumor

Section F: Viekira Pak/Viekira XR **OR** Technivie +/- ribavirin

31. *If patient has HIV coinfection,* is the patient currently receiving antiretroviral therapy (ART)? ❑ Yes ❑ No

32. *If the prescribed regimen is Viekira Pak/Viekira XR,* what is the patient's Metavir fibrosis score?
❑ F0 ❑ F1 ❑ F2 ❑ F3 ❑ F4 ❑ Other _____

Section G: Daklinza + Sovaldi +/- ribavirin

33. *If patient has genotype 3,* has laboratory testing for presence of NS5A inhibitor resistance-associated variants been performed? ❑ Yes ❑ No ❑ Unknown

34. Was the Y93H variant associated with daclatasvir resistance detected? ❑ Yes ❑ No

Section H: Zepatier +/- ribavirin

35. *If patient has genotype 1a,* was the patient tested for baseline NS5A resistance-associated polymorphisms?
❑ Yes ❑ No ❑ Unknown

36. Is one or more baseline NS5A resistance-associated polymorphisms present? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

OFFICE CONTACT: _____ PHONE: _____ EXT: _____