

# HEPATITIS C AGENTS PRIOR AUTHORIZATION FORM

(form effective 1/8/2024)



Keystone First

**PERFORMRx**<sup>SM</sup>  
Next Generation Pharmacy Benefits

Fax to PerformRx<sup>SM</sup> at **1-866-497-1387**, or to speak to a representative, call **1-800-588-6767**.

<b>Office contact</b> Name/phone:		Prescriber name:	
<b>LTC facility</b> Contact/phone:		State license #:	NPI:
Total # of pages:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:
Requested drug #1:	Directions:	Qty:	<input type="checkbox"/> 8 weeks <input type="checkbox"/> 16 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> Other: _____
Requested drug #2:	Directions:	Qty:	<input type="checkbox"/> 8 weeks <input type="checkbox"/> 16 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> Other: _____
Is the beneficiary currently being treated with the requested drug?			<input type="checkbox"/> No <input type="checkbox"/> Yes — Therapy start date: _____

### PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):

Deliver to: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Preferred Pharmacy Name:	
Pharmacy Phone #:	Pharmacy Fax #:
<input type="checkbox"/> I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.	

### SUBMIT DOCUMENTATION from the medical record for all items below.

For requests for NON-PREFERRED Hepatitis C Agents:

1. Documentation that the beneficiary tried and failed or has a contraindication or intolerance to the preferred Hepatitis C Agents. (See the Preferred Drug List for the list of preferred Hepatitis C Agents at: <https://papdl.com/preferred-drug-list>.)

List preferred medications tried: \_\_\_\_\_

2. Cirrhosis assessment documented by a recent noninvasive test and date of testing.

3. Genotype if one of the following (check the appropriate box for the beneficiary):

- The beneficiary is prescribed a non-pangenotypic regimen.
- The beneficiary is hepatitis C sofosbuvir-based, sofosbuvir/velpatasvir/voxilaprevir, or sofosbuvir plus glecaprevir/pibrentasvir treatment experienced.
- The beneficiary has decompensated cirrhosis and is prescribed ledipasvir/sofosbuvir.
- The beneficiary is treatment-naïve (with cirrhosis) and prescribed sofosbuvir/velpatasvir.

4. RAS (resistance-associated substitutions) testing and date of testing if one of the following (check the appropriate box for the beneficiary):

- The beneficiary is genotype 1a and prescribed elbasvir/grazoprevir.
- The beneficiary is genotype 1a, treatment-experienced, and prescribed ledipasvir/sofosbuvir.
- The beneficiary is genotype 3, treatment-naïve (with cirrhosis) or treatment-experienced (without cirrhosis) and prescribed 12 weeks of sofosbuvir/velpatasvir.

### For requests for THERAPEUTIC DUPLICATION of Hepatitis C Agents direct-acting antivirals (DAAs):

For a beneficiary taking more than one Hepatitis C Agents DAA product concomitantly:

The beneficiary has a medical reason for concomitant use of the requested products that is supported by peer-reviewed medical literature or national treatment guidelines.

### ATTESTATION from the prescriber for one of the items below.

Check the appropriate box for the beneficiary.

- The beneficiary is hepatitis C treatment naïve.
- The beneficiary has been treated for hepatitis C with the following treatment regimen:  
\_\_\_\_\_

### PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date:
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