Nevada Medicaid – Molina Healthcare
Hepatitis C Agents Prior Authorization Request Form

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. **Please FAX responses to: (844) 259-1689. Phone: (833) 685-2103.**

Member Information (required)			**Provider Information (required)**		
Member Name:			Provider Name:		
Molina ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

PA Requirements for ALL Agents (submission of medical records (e.g., chart notes, laboratory values) required):

Requested treatment duration (in weeks): _____

Does the recipient have a documented diagnosis of chronic hepatitis C? ☐ **Yes** ☐ **No**

HCV Genotype:_____HCV RNA level (pre-treatment): _____

Is the medication prescribed by or in consultation with a hepatologist, gastroenterologist, infectious disease specialist, or HIV specialist (certified through the American Academy of HIV Medicine)? ☐ **Yes** ☐ **Other:** _____

Is the recipient treatment-naïve? ☐ **Yes** ☐ **No**

If **no,** with which of the following therapeutic agents has the recipient experienced treatment failure (defined as viral relapse, breakthrough while on therapy, or is a non-responder to therapy) in previous treatment regimens:

Direct-acting antivirals: ❑ NS5A inhibitor ❑ NS5B inhibitor ❑ NS3/4A protease inhibitor

Other: ❑ Ribavirin ❑ Peginterferon alfa ❑ Interferon alfa

Please list all previous treatment regimens and dates of use: _____

_____

Recipient's current hepatic status: (select all that apply)

❑ Normal
❑ Mild hepatic impairment (Child-Pugh Class A, compensated cirrhosis)
❑ Moderate hepatic impairment (Child-Pugh Class B, decompensated cirrhosis)
❑ Severe hepatic impairment (Child-Pugh Class C, decompensated cirrhosis)
❑ Liver transplant recipient

Recipient's hepatic fibrosis level (e.g., METAVIR fibrosis score): _____

Will the recipient receive any other treatment in combination with requested therapy (e.g., ribavirin, peginterferon alfa, another HCV direct acting antiviral)? ☐ **Yes** ☐ **No**

If **yes**, please list concurrent therapy: _____

For pediatric patients only: Recipient's current weight: _____

Drug-Specific Information (required)

Daklinza® (daclatasvir)

Does the recipient have a documented diagnosis of chronic hepatitis C genotype 1 or 3? ☐ **Yes** ☐ **No**

Will the medication be used in combination with Sovaldi ® (sofosbuvir)? ☐ **Yes** ☐ **No**

If the recipient has decompensated cirrhosis or is a liver transplant recipient, will the medication be used in combination with ribavirin?

☐ **Yes** ☐ **No** ☐ **N/A**

Has the recipient experienced treatment failure (defined as viral relapse, breakthrough while on therapy, or is a non-responder to therapy) with a previous HCV NS5A treatment regimen? ☐ **Yes** ☐ **No**

Epclusa® (sofosbuvir/velpatasvir)

Will the recipient receive another HCV direct acting antiviral agent in combination with requested therapy? ☐ **Yes** ☐ **No**

Has the recipient experienced treatment failure (defined as viral relapse, breakthrough while on therapy, or is a non-responder to therapy) with a previous HCV NS5A treatment regimen? ☐ **Yes** ☐ **No**

If the recipient has decompensated cirrhosis or is a liver transplant recipient, will the medication be used in combination with ribavirin?

☐ **Yes** ☐ **No** ☐ **ribavirin ineligible** ☐ **N/A**

Harvoni® (ledipasvir/sofosbuvir)

Does the recipient have a documented diagnosis of chronic hepatitis C genotype 1, 4, 5, or 6? ☐ **Yes** ☐ **No**

Will the recipient receive another HCV direct acting antiviral agent in combination with requested therapy? ☐ **Yes** ☐ **No**

What is the recipient's pre-treatment HCV RNA (Documentation required)? ☐ **< 6 million IU/mL** ☐ **≥ 6 million IU/mL**

Has the recipient experienced treatment failure with a previous regimen that included peginterferon plus ribavirin with or without an NS3/4A protease inhibitor, e.g., Olysio® (simeprevir), Incivek® (telaprevir), Victrelis®(boceprevir)?

☐ **Yes** ☐ **No**

Has the recipient experienced treatment failure with a previous regimen that included Sovaldi®, except in combination with Olysio®?

☐ **Yes** ☐ **No**

Will the medication be used in combination with ribavirin? ☐ **Yes** ☐ **No** ☐ **ribavirin ineligible**

Has the recipient experienced treatment failure (defined as viral relapse, breakthrough while on therapy, or is a non-responder to therapy) with a previous HCV NS5A treatment regimen? ☐ **Yes** ☐ **No**

Mavyret® (glecaprevir/pibrentasvir)

Will the recipient receive another HCV direct acting antiviral agent in combination with requested therapy? ☐ **Yes** ☐ **No**

Has the recipient experienced treatment failure with a previous regimen that included an NS3/4A protease inhibitor, e.g., Olysio® (simeprevir), Incivek® (telaprevir), Victrelis® (boceprevir)? ☐ **Yes** ☐ **No**

Has the recipient experienced treatment failure with a previous regimen that included interferon, peginterferon, ribavirin, and/or Sovaldi® (sofosbuvir)? ☐ **Yes** ☐ **No**

Has the recipient experienced treatment failure (defined as viral relapse, breakthrough while on therapy, or is a non-responder to therapy) with a previous HCV NS5A treatment regimen? ☐ **Yes** ☐ **No**

Olysio® (simeprevir)

Does the recipient have a documented diagnosis of chronic hepatitis C genotype 1a, 1b or 4? ☐ **Yes** ☐ **No**

If the recipient has genotype **1a**, does the recipient have the NS3 Q8K polymorphism? ☐ **Yes** ☐ **No**

Has the recipient experienced treatment failure with a previous regimen that included an NS3/4A protease inhibitor, e.g., Olysio® (simeprevir), Incivek® (telaprevir), Victrelis® (boceprevir)? ☐ **Yes** ☐ **No**

Will the medication be used in combination with peginterferon alfa and ribavirin? ☐ **Yes** ☐ **No**

Will the medication be used in combination with Sovaldi® (sofosbuvir)? ☐ **Yes** ☐ **No**

Sovaldi® (sofosbuvir)

Does the recipient have a documented diagnosis of chronic hepatitis C genotype 1, 2, 3, or 4? ☐ **Yes** ☐ **No**

If the recipient is less than 12 years of age, does the recipient weigh at least 35kg? ☐ **Yes** ☐ **No**

Has the recipient experienced treatment failure with a previous regimen that included Sovaldi®? ☐ **Yes** ☐ **No**

Will the medication be used in combination with both peginterferon alfa and ribavirin? ☐ **Yes** ☐ **No**

Will the medication be used in combination with ribavirin only? ☐ **Yes** ☐ **No**

Will the medication be used in combination with Olysio® (simeprevir)? ☐ **Yes** ☐ **No**

If **yes**, has the recipient experienced treatment failure with a previous regimen that included an NS3/4A protease inhibitor, e.g., Olysio® (simeprevir), Incivek® (telaprevir), Victrelis® (boceprevir)? ☐ **Yes** ☐ **No**

Will the medication be used in combination with Daklinza® (daclatasvir)? ☐ **Yes** ☐ **No**

If **yes**, has the recipient experienced treatment failure (defined as viral relapse, breakthrough while on therapy, or is a non-responder to therapy) with a previous HCV NS5A treatment regimen? ☐ **Yes** ☐ **No**

Technivie® (ombitasvir, paritaprevir and ritonavir)

Does the recipient have a documented diagnosis of chronic hepatitis C genotype 4? ☐ **Yes** ☐ **No**

Will the medication be used in combination with ribavirin? ☐ **Yes** ☐ **No**

Will the recipient receive another HCV direct acting antiviral agent in combination with requested therapy? ☐ **Yes** ☐ **No**

Viekira Pak®, Viekira XR® (ombitasvir, paritaprevir, ritonavir tablets, dasabuvir)

What is the recipient's HCV genotype? ☐ **Genotype 1a** ☐ **Genotype 1b** ☐ **Mixed genotype 1**

Has the recipient experienced treatment failure with a previous regimen that included an NS3/4A protease inhibitor, e.g., Olysio® (simeprevir), Incivek® (telaprevir), Victrelis® (boceprevir)? ☐ **Yes** ☐ **No**

Has the recipient experienced treatment failure (defined as viral relapse, breakthrough while on therapy, or is a non-responder to therapy) with a previous HCV NS5A treatment regimen? ☐ **Yes** ☐ **No**

Will the recipient receive another HCV direct acting antiviral agent in combination with requested therapy? ☐ **Yes** ☐ **No**

Will the medication be used in combination with ribavirin? ☐ **Yes** ☐ **No**

Does the recipient have normal hepatic function with no fibrosis or only mild fibrosis (e.g., METAVIR fibrosis score less than or equal to F2)? ☐ **Yes** ☐ **No** **(submission of documentation required)**

Vosevi® (sofosbuvir/velpatasvir/voxilaprevir)

Will the recipient receive another HCV direct acting antiviral agent in combination with requested therapy? ☐ **Yes** ☐ **No**

Is the recipient a previous relapser to an HCV NS5A treatment regimen? ☐ **Yes** ☐ **No**

Does the recipient have normal hepatic function with no fibrosis or only mild fibrosis (e.g., METAVIR fibrosis score less than or equal to F2)? ☐ **Yes** ☐ **No** **(submission of documentation required)**

Does the recipient have HCV genotype 1a or 3? ☐ **Yes** ☐ **No**

If **yes,** is the recipient a previous relapser to a sofosbuvir-based regimen without an NS5A inhibitor? ☐ **Yes** ☐ **No**

Zepatier® (elbasvir/grazoprevir)

What is the recipient's HCV genotype? ☐ **Genotype 1a** ☐ **Genotype 1b** ☐ **Genotype 4**

If **genotype 1a**, has the recipient been tested for the presence of baseline NS5A resistance associated polymorphisms?
(e.g., polymorphisms at amino acid positions 28, 30, 31, or 93)

☐ **Presence detected**
☐ **Presence NOT detected**
☐ **Recipient has not been tested**

Will the recipient receive another HCV direct acting antiviral agent in combination with requested therapy? ☐ **Yes** ☐ **No**

Will the medication be used in combination with ribavirin? ☐ **Yes** ☐ **No**

Has the recipient experienced treatment failure with a previous regimen that included peginterferon alfa, ribavirin, and an NS3/4A protease inhibitor, e.g., Olysio® (simeprevir), Incivek® (telaprevir), Victrelis® (boceprevir)? ☐ **Yes** ☐ **No**

Has the recipient experienced treatment failure with a previous regimen that included peginterferon alfa and ribavirin only?

☐ **Yes** ☐ **No**

Please attach all supporting documentation to request

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call (833) 685-2103.
This form may be used for non-urgent requests and faxed to (844) 259-1689.