TUFTS Health Plan

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tuftshealthplan.com

Hepatitis C Medication Request Form

Today's date ___/___/___

THIS FORM CAN BE USED FOR THE FOLLOWING PLANS AND PRODUCTS:

Fax to 617.673.0956:	**Fax to 617.673.0988:**
☐ Tufts Health Plan Medicare Preferred	☐ Tufts Health Plan Commercial Plans
☐ Tufts Health Plan Senior Care Options	☐ Tufts Health Direct
☐ Tufts Health Unify	☐ Tufts Health Freedom Plan
	☐ Tufts Health Together

Member Information

Last name:	First name:
Member ID#:	Member DOB:

Prescriber Information

Prescribing Clinician:	Phone #:
Specialty (required):	Secure Fax #:
NPI #:	DEA/xDEA:
Prescriber Point of Contact Name (POC) (if different than provider):	
POC Phone #:	POC Secure Fax #:

Medication Information

Requested drug(s):

☐ Harvoni ☐ Viekira Pak ☐ Viekira XR ☐ Epclusa ☐ Sovaldi ☐ Technivie
☐ Zepatier ☐ Daklinza ☐ Ribavirin (generic) ☐ Ribavirin (Brand) ☐ Other:_____

Dose(s):_____ Requested Duration of Treatment:_____ weeks

Type of therapy: ☐ Initial ☐ Continuation - weeks remaining:_____ Anticipated start date:_____

Clinical Information

Diagnosis:
☐ B18.2 Hepatitis C (chronic)

HCV Genotype: ☐1a ☐1b ☐2 ☐3 ☐4 ☐5 ☐6

Stage of Hepatic Fibrosis: ☐F0 ☐F1 ☐F2 ☐F3 ☐F4

For members with early stage liver disease (Metavir Score F0-F2), please describe the medical necessity for requesting treatment at this time:

_____
_____
_____

Is the medication prescribed by a gastroenterologist, infectious disease specialist, or hepatologist?	☐ Yes	☐ No
Was the staging of hepatic fibrosis performed by a specialist through one of the following? *Please check all that apply and attach documentation including medical records and results of diagnostic tests:* ☐ Liver biopsy confirming METAVIR score ☐ Transient elastography (Fibroscan) score ☐ Fibrotest (FibroSURE) score of greater ☐ Radiological imaging	☐ Yes	☐ No

☐ APRI score ☐ Physical findings or clinical evidence consistent with cirrhosis as attested by the prescriber		
Is there documented evidence of chronic liver disease, or in the absence of chronic liver disease, serologic evidence of persistent infection for at least six months?	☐ Yes	☐ No
Does the patient have HIV coinfection?	☐ Yes	☐ No
Was Hepatitis B screening been performed?	☐ Yes	☐ No
If patient has active Hepatitis B infection, has the risk of Hepatitis B reactivation been assessed? *Caution: FDA has warned about the risk of Hepatitis B reactivating in some patient treated with direct acting antiviral agents for Hepatitis C. AASLD recommends treating Hepatitis B concurrently or prior to Hepatitis C treatment.*	☐ Yes	☐ No
Does the patient have severe renal impairment or end-stage renal disease, or require dialysis? Confirm the patient's GFR range: ☐ 0 – 14 ☐ 15 – 29 ☐ > / = 30	☐ Yes	☐ No
Has the patient been previously treated for Hepatitis C and failed treatment? *If yes, when?* _____*What treatment(s)?* _____ Response to treatment: ☐ Relapsed ☐ Partial response ☐ Null response (< 2 log reduction in HCV RNA at week 12) ☐ Did not complete Adverse reaction? ☐ Yes ☐ No	☐ Yes	☐ No
HCV RNA levels: Baseline within 6 months of beginning treatment (required): _____ IU/mL Date of lab work: _____ **Post-therapy** 12 weeks after completion of treatment: _____ IU/mL Date of lab work: _____		

Has there been confirmation that the patient does not have a genotype 1a with NS3 Q80K polymorphism? (Olysio only)	☐ Unknown	☐ Yes	☐ No
Has there been confirmation that the patient does not have a genotype 1a with a baseline NS5A polymorphism? (Zepatier only)	☐ Unknown	☐ Yes	☐ No
Will hepatic laboratory testing be performed prior to therapy, at treatment week 8, and as clinically indicated?		☐ Yes	☐ No
Does the patient have a diagnosis of hepatocellular carcinoma that meets Milan criteria?		☐ Yes	☐ No
If the patient require a dosage form other than ribavirin 200mg capsules or tablets, document clinical reason and provide dosage form. *Dosage form:*_____ *Clinical reason*: _____			
Are any of the following statements true? ☐ Patient is pregnant or is planning to become pregnant within 6 months after completion of treatment ☐ Patient is male with a female partner who is pregnant or is planning to become pregnant within 6 months after completion of treatment ☐ None of the above			
Is the member currently awaiting a liver transplant?		☐ Yes	☐ No
Does the member have cirrhosis? *If yes, please choose one:* ☐ Compensated (Child-Turcotte-Pugh Class A; no major complication of cirrhosis) ☐ Decompensated (Child-Turcotte-Pugh Class B or C)		☐ Yes	☐ No
Is the patient being managed in a liver transplant center?		☐ Yes	☐ No
Is the member actively participating in illicit substance abuse or alcohol abuse?		☐ Yes	☐ No
Is there documented attestation that the member has been assessed for potential nonadherence?		☐ Yes	☐ No
Is the member is receiving substance or alcohol abuse counseling services or seeing an addiction specialist as an adjunct to HCV treatment?		☐ Yes	☐ No
Has a treatment plan been developed and discussed with the patient?		☐ Yes	☐ No
Did the prescriber identify any potential issues with adherence? *If yes, please describe:* _____		☐ Yes	☐ No
Have drug interactions been reviewed and evaluated?		☐ Yes	☐ No

THIS SECTION APPLIES TO TUFTS HEALTH PLAN MEDICARE PREFERRED, TUFTS HEALTH PLAN SENIOR CARE OPTIONS and TUFTS HEALTH UNIFY only.

Does this member reside in long-term care? ☐ **Yes** ☐ **No**

Is the member enrolled in Hospice? ☐ **Yes** ☐ **No** If no, disenrollment date: _____

Is the drug related to the terminal illness or related conditions? ☐ Yes ☐ No

Provide an explanation of why the drug being prescribed if unrelated to the terminal illness/related conditions:

_____

Is this a request for a formulary tier exception (excludes non formulary medications and medications on the specialty tier)*? ☐ **Yes** ☐ **No**

*If yes, a supporting statement from the prescribing physician is required. Please specify the request: (1) formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome; or (4) I want to pay a lower copayment because another drug is same therapeutic category but lower copayment or my drug was in a lower tier and it was moved to a higher tier and I want the lower copayment.

By checking the following box, I certify that applying the standard review time frame may seriously jeopardize my patient's life, health, or ability to attain, maintain, or regain maximum function. ☐ Request for expedited review

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____

Prescriber signature (STAMP NOT ACCEPTED) Date