



Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
 P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Hepatitis Antiviral Agents Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at www.mass.gov/druglist.

Member information

Last name _____ First name _____ MI _____
 MassHealth member ID # _____ Date of birth _____
 Gender (Check one.) F M Member's place of residence home nursing facility

Diagnosis

Hepatitis C
 Acute Chronic
 HIV-coinfection Renal impairment. Creatinine clearance _____ Status post-liver transplant
 HCV Genotype 1a 1b 2 3 4 5 6 Other _____
 Treatment-experienced (Please complete the section for Prior Hepatitis Treatment.) Treatment-naïve
 Treatment initiation Anticipated start date _____ Anticipated end date _____
 Continuation of therapy, current week _____
 Chronic Hepatitis B

Fibrosis Staging

Please indicate below and attach documentation including medical records and results of diagnostic tests assessing liver disease staging (e.g., APRI, Fibroscan, Fibrosure, FIB-4). Staging information must clearly demonstrate early stage (Metavir Score F0 to F2) or advance liver disease (Metavir Score F3 to F4). If results are inconclusive or if imaging studies are performed and are not suggestive of cirrhosis, further diagnostic testing may be required.

Metavir Score F0 to F2 Metavir Score F3 to F4 Other _____

Does the member have cirrhosis? Yes No

If yes, please indicate Child-Turcotte-Pugh (CTP) class. (Please attach calculations.) A B C

Drug Interactions

Does the member currently take prescription or over-the-counter medications that may interact with the requested regimen (e.g., proton pump inhibitors, H2-receptor antagonists, anticonvulsants, HIV antiretrovirals, HMG CoA reductase inhibitors, antimycobacterials, St. John's Wort)?

Yes. Please attach medication list and describe the plan to manage the interaction(s). No

Lab Values

Baseline HCV RNA lab value _____ Date drawn _____

Prior Hepatitis Treatment

Drug name _____ Dates/duration of use _____

Please indicate treatment outcome. Adverse reaction Null responder Partial responder
 Relapser Other

Briefly describe details. _____

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Please indicate treatment outcome. Adverse reaction Null responder Partial responder
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Drug name _____ Dates/duration of use _____

Please indicate treatment outcome. Adverse reaction Null responder Partial responder
 Relapser Other

Briefly describe details. _____

Complete Treatment Regimen (Check All that Apply)**HCV Combination Agents**

- | | |
|---|--|
| <input type="checkbox"/> ledipasvir/sofosbuvir | <input type="checkbox"/> Viekira Pak (ombitasvir/paritaprevir/ritonavir/dasabuvir) |
| <input type="checkbox"/> Mavyret (glecaprevir/pibrentasvir) | <input type="checkbox"/> Vosevi (sofosbuvir/velpatasvir/voxilaprevir) |
| <input type="checkbox"/> sofosbuvir/velpatasvir | <input type="checkbox"/> Zepatier (elbasvir/grazoprevir) |

Dose/frequency _____ Duration of therapy _____

For sofosbuvir/velpatasvir requests only, for members with HCV genotype 3 who are treatment-naïve with compensated cirrhosis or treatment-experienced without cirrhosis, please indicate if NS5A resistance-associated substitution Y93H is present. (Please attach laboratory testing results.) Yes NoFor Zepatier requests only, for members with HCV genotype 1a, please indicate if baseline NS5A polymorphisms at amino acid positions 28, 30, 31 or 93 are present. (Please attach laboratory testing results.) Yes No**HCV Single Agents**

-
- Sovaldi (sofosbuvir)

Dose/frequency _____ Duration of therapy _____

Pegylated Interferon

-
- Pegasys (peginterferon alfa-2a)
-
- Pegintron (peginterferon alfa-2b)

Dose/frequency _____ Duration of therapy _____

Ribavirin

- | | |
|---|---|
| <input type="checkbox"/> Rebetol solution | <input type="checkbox"/> ribavirin 200 mg capsule |
| <input type="checkbox"/> ribavirin dose pack | <input type="checkbox"/> ribavirin 400 mg or 600 mg |
| <input type="checkbox"/> None. Please explain the clinical rationale for not using ribavirin below. | |

Dose/frequency _____ Duration of therapy _____

Please indicate if using ribavirin 200 mg tablets. Yes No

Please describe medical necessity for use of the other products over the 200 mg tablet.

If applicable, please explain the clinical rationale for not using ribavirin. _____

HBV Antiviral

Vemlidy (tenofovir alafenamide)

Dose/frequency _____ Duration of therapy _____

For members not previously treated with a nucleoside analog, please explain the clinical rationale for Vemlidy use over entecavir. _____

Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

Prescriber information

Last name* _____ First name* _____ MI _____

NPI* _____ Individual MH Provider ID _____

DEA No. _____ Office Contact Name _____

Address _____ City _____ State _____ Zip _____

E-mail address _____

Telephone No.* _____ Fax No.* _____

* *Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____