Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Print Clear

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

☐ Chronic Hepatitis C

☐ 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

Social History

Does the member indicate that he or she has a substance use disorder (drugs or alcohol)? ☐ Yes ☐ No

If yes, does the member indicate that he or she is currently enrolled in a substance use program or alcohol support program? ☐ Yes ☐ No. Please explain _____

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 and Treatment Plan

Hepatitis C viral load will be measured following week four of treatment and, if detectable, following week six of treatment. If viral load is detectable at week four of treatment and has increased by greater than 10-fold (>1 log10 IU/mL) at week six, treatment will be discontinued. ☐ Yes. ☐ No. Explain why not. _____

Initial request

Baseline HCV RNA lab value _____ Date drawn _____

Request for continuation of therapy

HCV RNA lab value at week 4 _____ Date drawn _____

RNA lab value at week 6, if applicable _____ 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. _____

Drug name _____ Dates/duration of use _____

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

Briefly describe details. _____

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

☐ Epclusa (sofosbuvir/velpatasvir)
☐ Harvoni (ledipasvir/sofosbuvir)
☐ Mavyret (glecaprevir/pibrentasvir)
☐ Technivie (ombitasvir/paritaprevir/ritonavir)
☐ Viekira Pak (ombitasvir/paritaprevir/ritonavir/ dasabuvir)
☐ Viekira XR (dasabuvir/ombitasvir/paritaprevir/ ritonavir extended-release)
☐ Vosevi (sofosbuvir/velpatasvir/voxilaprevir)
☐ Zepatier (elbasvir/grazoprevir)

Dose/frequency _____ Duration of therapy _____

For Epclusa requests only, for members with HCV genotype 3 who are treatment-naïve with compensated cirrhosis or treatment-experienced without cirrhosis, please indicate if baseline NS5A Y93H polymorphism is present. (Please attach laboratory testing results). ☐ Yes. ☐ No

For 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.

over

HCV Single Agents

☐ Daklinza (daclatasvir) ☐ Sovaldi (sofosbuvir)
☐ Olysio (simeprevir)

Dose/frequency _____ Duration of therapy _____

For members with HCV genotype 3 who are treatment-naïve with compensated cirrhosis or treatment-experienced without cirrhosis, please indicate if baseline NS5A Y93H polymorphism is present. (Please attach laboratory testing results). ☐ Yes. ☐ No.

Pegylated Interferon

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

Dose/frequency _____ Duration of therapy _____

Ribavirin

☐ Rebetol solution
☐ ribavirin dose pack
☐ ribavirin 200 mg capsule
☐ ribavirin 400 mg or 600 mg
☐ 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*

over

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 _____