COLORADO
Department of Health Care Policy & Financing

Hepatitis C Treatment Prior Authorization (PA) Request Form

Fax completed form and supporting documentation to 1-800-424-5881

Hepatitis C PA criteria is listed on the Preferred Drug List: https://www.colorado.gov/hcpf/pharmacy-resources.

Member name: _____ DOB: _____ Medicaid ID: _____
If patient is less than 18 years, indicate patient weight (for dosing): _____kg or lbs (circle one)

Physician: _____ Phone: _____ Fax: _____ NPI: _____

Prescriber signature (required): _____ Date: _____
Is the prescriber an infectious disease specialist, gastroenterologist, or hepatologist (circle one)? □ No □ Yes
If no, is the requested drug being prescribed in consultation with an expert in hepatitis C treatment or by a primary care provider (PCP) that has received sufficient education to safely prescribe hepatitis C medications (circle one)? □ No □ Yes

1. Has the member previously received direct acting antivirals (DAAs) or been treated for hepatitis C (circle one)? □ No □ Yes **If YES,** complete questions #1-7. **If NO,** complete ONLY questions #1-4.
2. Prescriber attests to meeting one of the following (check one):
   - □ Member has a diagnosis of chronic HCV infection (presence of HCV RNA viral load for ≥ 6 months)
   - □ Member has a diagnosis of acute HCV infection in the setting of solid organ transplant
   - □ Member will be treated upon initial HCV diagnosis (acute infection) and acknowledges that the rate of spontaneous resolution of acute infection has been considered as part of assessing the need to initiate antiviral therapy (acute HCV infection may spontaneously clear in 20-50% of patients)
3. Prescriber attests that the member has been counseled about the importance of adherence to hepatitis C medication regimen (circle one)? □ No □ Yes
4. Fill in requested drug regimen (strength and duration) in the corresponding table below:

Initial Treatment Requests:

Drug	**Strength/ Formulation**	**Duration (weeks)**	**Preferred Initial Treatment Regimens** *(GT-Genotype, NC-No-Cirrhosis, CC-Compensated Cirrhosis, DC-Decompensated Cirrhosis)*
Epclusa: 200mg-50mg tablet 150mg-37.5mg pellet pack 200mg-50mg pellet pack Sofosbuvir/Velpatasvir 400mg-100mg			**Tablets** may be approved for members 3 years and older or weighing at least 17 kg for GT 1-6 who are NC, have CC (Child-Pugh A); or in combination with ribavirin in DC; **Pellet pack** may be approved for members ≥ 3 years of age weighing less than 17 kg or members 3 years of age or older that are unable to take/swallow ledipasvir/sofosbuvir oral tablets
Harvoni: 45mg-200mg tablet 45mg-200mg pellet pack 33.75 mg-150 mg pellet pack Ledipasvir/sofosbuvir 90mg-400mg tablet			**Tablets** may be approved for members 3 years and older for GT 1, 4-6 who are NC, have CC; or GT 1 in combination with ribavirin in DC; or GT 1,4 in combination with ribavirin for liver transplant recipients who are NC or have CC; **Pellet pack** may be approved for members 3 years of age or older weighing less than 17 kg or members 3 years of age or older that are unable to take/swallow ledipasvir/sofosbuvir oral tablets
Mavyret tablet	100mg-40mg		**Tablets** may be approved for members 3 years and older for GT 1-6 who are NC or have CC (Child-Pugh A)

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Retreatment Requests (prior exposure to DAA therapy):

Drug	**Strength/ Formulation**	**Duration (weeks)**	**Preferred Regimens For Retreatment or Treatment Experienced** *(GT-Genotype, NC-No-Cirrhosis, CC-Compensated Cirrhosis, DC-Decompensated Cirrhosis)*
Mavyret tablet	100mg-40mg		**Tablets** may be approved for members 3 years and older for GT 1-6 who are NC or have CC (Child-Pugh A), OR for members 3 years and older with GT 1 who previously have been treated with a regimen containing an HCV NS5A inhibitor or an NS3/4A protease inhibitor, but not both;
Epclusa: 200mg-50mg tablet 150mg-37.5mg pellet pack 200mg-50mg pellet pack Sofosbuvir/Velpatasvir 400mg-100mg			**Tablets** may be approved for members 3 years and older or weighing at least 17 kg for GT 1-6 who are NC, have CC (Child-Pugh A); or in combination with ribavirin in DC; **Pellet pack** may be approved for members ≥ 3 years of age weighing less than 17 kg or members 3 years of age or older that are unable to take/swallow ledipasvir/sofosbuvir oral tablets
Vosevi tablet	400mg-100mg-100mg		May be approved for members 18 years or older with chronic HCV infection who are NC, have CC (Child-Pugh A) AND meet one of the following: • GT 1-6 and has previously failed treatment with a regimen containing an NS5A inhibitor (such as ledipasvir, daclatasvir, or ombitasvir) OR • GT 1a or 3 and has previously failed treatment with a regimen containing sofosbuvir without an NS5A inhibitor

5. List previous treatment regimen received, and date received:
   Regimen _____ Date _____
6. Indicate genotype of previous treatment and current genotype (if known):
   Previous _____ Current _____
7. Was the entire treatment regimen completed (circle one)? □ No □ Yes
   If no (early discontinuation occurred), please describe and provide/submit the following additional information Any information regarding adherence to previously trialed regimen(s) and current chronic medications
   a. Adverse effects experienced with previous treatment regimen
   b. Concomitant therapies received during previous treatment
   c. For Vosevi regimens, any documented evidence of prior hepatitis B virus (HBV) infection and/or verification that the member has been tested for active HBV infection prior to initiating treatment

_____
_____
_____

Non-Preferred DAAs (if applicable to the request)
If not prescribing a preferred treatment regimen, provide rationale and supporting documentation (Acceptable rationale may include member has initiated treatment on a non-preferred drug and needs to complete therapy, patient-specific medical contraindications to a preferred treatment).

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