Pharmacy Prior Authorization

AETNA BETTER HEALTH OF NEW JERSEY (MEDICAID)

Hepatitis C Medications

This fax machine is in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Aetna Better Health of New Jersey at **1-855-296-0323**. Please contact Aetna Better Health of New Jersey at **1-855-232-3596** with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Hepatitis C Medications. Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless stated otherwise.

Prior authorization for hepatitis C treatment requires submission of medical records with the prior authorization request. *Incomplete and/or illegible request forms may result in a denial including those without medical records.*

Mavyret (preferred)
Vosevi
Zepatier
Harvoni
Epclusa
Sovaldi
Pegasys/Peg-Intron
Ribavirin

Patient Information

Patient Name: ____________________________ Patient Phone #: ____________________________

Member ID #: ____________________________ Patient DOB: ____________________________

Prescriber Information

Prescriber's Name: ________________________ Prescriber's NPI: ________________________

Office Phone: ____________________________ Office Address: ____________________________

Prescriber's E-mail: ________________________ Office Contact Name: ______________________

Office Fax: ______________________________ City/State/ZIP: ____________________________

Requested Treatment Regimen (Check all medications requested):

Preferred Agents:

___ Mavyret
___ sofosbuvir-velpatasvir

Non-Preferred Agents:

___ Vosevi ___ Ribavirin
___ Harvoni ___ Sovaldi
___ Epclusa ___ Zepatier ___ Pegasys/Peg-Intron

Treatment Duration:

Criteria for Approval

Decisions are based on the criteria established by the state of New Jersey, which may be found at: https://www.aetnabetterhealth.com/newjersey/providers/pharmacy

Please answer all required questions below **and** provide relevant supporting information including medical records.

1.	**Is this a request to continue a previously approved treatment (i.e., previous authorization is on file under this plan)?** [If yes, no further questions. The remainder of this form does not need to be completed.] NOTE: HCV-RNA levels **must be** submitted with each renewal request as described below: • For 8- and 12-week regimens: HCV-RNA levels at treatment week 4 and 12 • For 24- and 48-week regimens: HCV-RNA levels at treatment week 4, 12 and 24 NOTE: Prescription refill history will be reviewed to confirm patient adherence to medication regimen.	Yes No
2.	**Is the patient 18 years of age or older with a diagnosis of Hepatitis C, genotype 1-6 confirmed by detectable serum HCV RNA by quantitative assay completed within the last 90 days?** NOTE: Labs must be submitted with request.	Yes No
3.	**Does the prescriber agree to submit HCV-RNA levels at treatment week 4, 12, (and week 24 for longer regimens) and 3 months post treatment?**	Yes No
4.	**Does the patient have ANY of the following high-risk factors?** A) Type 2 or 3 essential mixed cryoglobulinemia with end-organ manifestations B) HIV co-infection C) Nephrotic syndrome or membranoproliferative glomerulonephritis or proteinuria D) Liver transplant (please circle which apply)	Yes No

The patient's treatment status (circle one):

Treatment Naïve   Prior Relapse   Prior Partial Responder   Null Responder   Status-Post Liver Transplant

Prior Hepatitis C Treatments (circle all applicable):

Mavyret   Epclusa   Vosevi   Harvoni   Sovaldi   Olysio   Viekira Pak/Viekira XR
Incivek   Victrelis   Daklinza   Technivie   Zepatier   ribavirin   peginterferon

Is the treatment combined with ribavirin?	Yes No N/A
If treatment is combined with ribavirin:	☐ Patient has no contraindication to ribavirin (See PI for complete list)
	☐ Neither the patient nor the partner of the patient is pregnant
	☐ Patient or partner is of childbearing age AND the patient has been OR will be instructed to practice effective contraception during therapy AND for 6 months after stopping ribavirin therapy.

Does the member have a limited life expectancy (<12 months due to non-liver related comorbidities)?   Yes   No

If member received treatment under another plan, date of prior treatment initiation:

Diagnosis / Dosing (all sections required)		
Diagnosis (include ICD10 Code):	**Genotype:** (must submit lab results completed within 90 days of treatment initiation) NS5A polymorphism (circle any that apply) 28 30 31 93	**Viral Load (HCV-RNA):** (must submit lab results) Baseline (within 90 days of treatment initiation): Treatment Week 4: Treatment Week 12: Treatment Week 24:
Please circle **fibrosis level** (**required**) and submit supporting documentation with request: **F1** **F2** **F3** **F4**		
Does the patient have cirrhosis? Yes No	If Yes, please indicate the Child-Pugh Score:	
Does the patient have hepatocellular carcinoma meeting Milan criteria (awaiting liver transplantation)? Yes No	If Yes, please provide the potential transplant date:	
Additional Information: Please elaborate on any yes/no questions that need more explanation		

By signing, the prescribing or authorizing clinician is attesting that the information on this form is accurate as of this date and that documentation supporting the above information is recorded in the patient's medical chart. Requests for Hepatitis C medications must be submitted with supporting medical records.

Prescriber (Or Authorized) Signature **Date**