Pharmacy Prior Authorization

AETNA BETTER HEALTH OF NEW JERSEY (MEDICAID)

Hepatitis C Medications

This fax machine is located 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.*

Mayvret (preferred)	Harvoni	Olysio
Vosevi	Epclusa	Technivie
Zepatier	Sovaldi	Pegasys/Peg-Intron
Daklinza	Viekira Pak/Viekira XR	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):

____ Mayvret (preferred)	____ Harvoni	____ Olysio
____ Vosevi	____ Epclusa	____ Technivie
____ Zepatier	____ Sovaldi	____ Pegasys/Peg-Intron
____ Daklinza	____ Viekira Pak/Viekira XR	____ Ribavirin

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.	**Is the treatment prescribed by a specialist in gastroenterology, hepatology, infectious disease, or liver transplant?** (please circle which specialty)	Yes No
4.	**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
5.	**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):

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

Patient's most recent hemoglobin (value and date):

Patient's most recent creatinine clearance or EGFR (value and date):

Is the patient pregnant, or is the male's female partner pregnant? Yes No N/A

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

Is member unable to take ribavirin or considered ribavirin intolerant? Yes No

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? If Yes, please indicate the Child-Pugh Score:

Yes No

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**