Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Harvoni® (ledipasvir /sofosbuvir)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

What is the provider's specialty?

☐ Gastroenterologist ☐ Hepatologist ☐ Infectious disease specialist ☐ Other: _____

Product Information

☐ New request

☐ Request to extend treatment for a total of _____ weeks*

Drug product: ☐ Harvoni 90mg-400mg

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Requested Duration:

☐ 8 weeks ☐ 12 weeks ☐ 24 weeks

***Treatment extensions are not covered**

Drug cost information

The wholesale acquisition cost for Harvoni is $1,125 for each tablet. The 12-week cost of treatment with this drug is $94,500.

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Must have chronic hepatitis C genotype 1, 4, 5, or 6 (documentation of a hepatitis C ICD10 code* from within the last 12 months must be submitted to Priority Health)
2. Must have fibrosis stage ≥ F2
3. Must be age 12 or older
4. Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist
5. Must first try Zepatier for genotype 1 and 4
6. Must first try Epclusa for genotype 5 and 6
7. The approved duration of treatment is based on the recommended durations of therapy in the most recent AASLD/IDSA guidelines

* Approved ICD10 codes are provided in the Additional Information section

All fields must be complete and legible for review. Your office will receive a response via fax.

Last reviewed 05/2017
Updated 05/2018

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Chronic hepatitis C infection (documentation of a hepatitis C ICD10 code from within the last 12 months must be submitted to Priority Health)

☐ *Other – the patient's condition is:* _____

B. What is the patient's HCV genotype?

☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

C. Has the patient previously received treatment for chronic hepatitis C?

☐ Yes, the drug(s) used were: _____

☐ No

D. If genotype 1 or 4, has the patient first tried Zepatier?

☐ Yes, for _____ weeks from _____ (list dates)

☐ No, because _____

E. If genotype 5 or 6, has the patient first tried Epclusa?

☐ Yes, for _____ weeks from _____ (list dates)

☐ No, because _____

F. Please indicate patient's current fibrosis stage:

☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4

G. What methodology was used to determine fibrosis stage (results and/or labs must be sent in with request)?

☐ METAVIR ☐ APRI
☐ Ishak ☐ FIB-4
☐ Knodell ☐ Fibrotest/Fibrosure
☐ Fibroscan
☐ Other: _____

1. For serologic-based methods, what is the calculated score? _____

H. Does the patient have HIV co-infection?

☐ Yes
☐ No

I. Does the patient have liver cirrhosis?

☐ Yes (Fax supporting chart notes to Priority Health)
☐ No

J. If cirrhosis is present, is it compensated or decompensated?

☐ Compensated
☐ Decompensated
☐ NA

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Last reviewed 05/2017
Updated 05/2018

Additional Information

One Harvoni-based treatment regimen is covered in a lifetime, unless the patient has confirmed cirrhosis. When treatment is authorized, the quantity and length of treatment is limited to FDA-approved dosing (see approved duration of treatment in precertification requirements).

There is unreliable evidence to support treatment extensions at this time, even for patients with undetectable viral loads (less than 25 IU/mL) and detectable viral particles. Patients with a detectable HCV RNA viral load after 4 weeks of treatment should have their viral load tested after an additional 2-weeks of treatment. If the viral load has more than a 10-fold increase (more than 1 $\log_{10}$ IU/mL) on repeat testing at 6 weeks, treatment should be discontinued. If the 6-week repeat viral load testing is less than a 10-fold increase, the patient should complete treatment and the prescriber should check the patient's RNA HCV viral load 12 weeks following completion of therapy (SVR12).

For purposes of determining a cirrhotic patient's eligibility for retreatment with Harvoni, Priority Health defines treatment failure as a detectable SVR12 RNA HCV viral load. Priority Health covers one retreatment for cirrhotic patients who previously failed a Harvoni-based treatment regimen.

Approved ICD10 Codes for Hepatitis C

ICD10	ICD10 Label
B17.11	Acute hepatitis C with hepatic coma
B18.2	Chronic viral hepatitis C
B18.8	Other chronic viral hepatitis
B18.9	Chronic viral hepatitis, unspecified
B19.0	Unspecified viral hepatitis with hepatic coma
B19.21	Unspecified viral hepatitis C with hepatic coma

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