SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Hepatitis-C Antiviral Drugs (Non-Preferred)

(Mavyret™ and Mavyret™ Pellet packs are Preferred no PA required.)

DRUG REQUESTED: (Check below the requested Hepatitis-C therapy that applies)

❑ **Epclusa®** ❑ **Epclusa® Pellet packs** ❑ **sofosbuvir/velpatasvir**	❑ **Harvoni®**	❑ **Incivek®**
❑ **interferon**	❑ **ledipasvir/sofosbuvir** (generic Harvoni®)	❑ **Olysio™** (discontinued)
❑ **Pegasys® Proclick/ syringe/kit/vial**	❑ **Sovaldi®**	❑ **Technivie™**
❑ **Viekira Pak™**	❑ **Viekira XR™**	❑ **Vosevi®**
❑ **Zepatier®**		

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

(Continued on next page)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Prescriber Specialty: Non-Preferred Hepatitis-C medication must be prescribed by one of the specialty physicians below or be in consultation with one of the following: (check applicable box be low):

❑ Gastroenterologist	❑ Hepatologist	❑ Transplant Specialist
❑ Infectious Disease	❑ Other: _____	

DIAGNOSIS: Check box below that applies to ensure authorization will not be delayed.		
❑ Acute or Chronic Hepatitis C	❑ Compensated cirrhosis	❑ Hepatocellular carcinoma
❑ Status post-liver transplant	❑ Decompensated cirrhosis (Child-Pugh score class B or C)	
❑ Severe renal impairment (eGFR < 30mL/min/1.73m^2) or end stage renal disease requiring hemodialysis		

HCV Genotype: Check box below that applies		
❑ 1	❑ 2	❑ 3
❑ 4	❑ 5	❑ 6

Choose One: ❑ Treatment initiation ❑ Continuation of therapy, current week: _____

PREVIOUS HEPATITIS C TREATMENTS

- ❑ Treatment naïve
- ❑ Treatment experienced please list treatment:

_____

_____

Document dates received:

_____

_____

Medication being provided by Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

***Approved by Pharmacy and Therapeutics Committee:** 10/19/2017
REVISED/UPDATED/REFORMATTED: ~~6/25/2017; 8/30/2017; 12/30/2017; 1/29/2018; 6/15/2018; 8/22/2018; 5/24/2019; 12/4/2019; 12/21/2020; 6/28/2022; 12/27/2022; 11/7/2023;~~ **6/17/2026**