



Prior Authorization
<p>JOHNS HOPKINS HEALTH PLANS Epclusa - Priority Partners MCO</p> <p>This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at <b>1-410-424-4607</b>. Please contact Johns Hopkins Health Plans at <b>1-888-819-1043</b> with questions regarding the Prior Authorization process.</p> <p>When conditions are met, we will authorize the coverage of Epclusa - Priority Partners MCO.</p>

Drug Name (select from list of drugs shown) EPCLUSA (sofosbuvir/velpatasvir)
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Quantity	Frequency	Strength
Route of Administration	Expected Length of Therapy	

Patient Information	
Patient Name:	_____
Patient ID:	_____
Patient Group No.:	_____
Patient DOB:	_____
Patient Phone:	_____

Prescribing Physician	
Physician Name:	_____
Physician Phone:	_____
Physician Fax:	_____
Physician Address:	_____
City, State, Zip:	_____

<b>Diagnosis:</b> _____	<b>ICD Code:</b> _____
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Comments: _____
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<b>Please circle the appropriate answer for each question.</b>	
1. Does the patient have a diagnosis of chronic hepatitis C?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
2. Has the patient had a hepatitis C infection for 6 months or greater?	<input type="checkbox"/> Y <input type="checkbox"/> N

[If no, no further questions.]	
3. Has chronic disease been supported by one of the following: A) lab testing such as an HCV antibody or HCV RNA test completed 6 months apart, B) HCV diagnosis documented in prescribers' note from the past office visit(s), or C) exposure risk history documented in prescribers' notes from the past office visit(s)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
4. Has the patient's genotype and subtype been determined?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
5. Has the patient undergone a liver biopsy or another accepted test that has demonstrated a liver fibrosis status?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
6. Does the patient have a diagnosis of cirrhosis?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, skip to question 13.]	
7. Has clinical documentation showing support for the diagnosis, prior hepatitis C treatment history, and treatment response (Relapsed, Partial Responder, Non-Responder, Toxicity, or Reinfection), and a planned treatment been submitted and dated within 90 days of the prior authorization request?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
8. Does the patient have baseline laboratory values including HCV RNA, total bilirubin, albumin, and INR level within 90 days of prior authorization request?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
9. Has the patient been prescribed a ribavirin-containing regimen?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, skip to question 19.]	
10. Does the patient have baseline hemoglobin, hematocrit, and platelet counts within 90 days of the prior authorization request?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
11. Is the patient or their partner of childbearing age?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, skip to question 19.]	

12. Is the patient utilizing 2 forms of contraception for the duration of therapy, as well as for 6 months post-treatment?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
13. Has clinical documentation showing support for the diagnosis, prior hepatitis C treatment history, treatment response (Relapsed, Partial Responder, Non-Responder, Toxicity, or Reinfection), and a planned treatment been submitted and dated within 180 days of the prior authorization request?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
14. Does the patient have baseline HCV RNA level within 180 days of prior authorization request?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
15. Has the patient been prescribed a ribavirin-containing regimen?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, skip to question 19.]	
16. Does the patient have baseline hemoglobin, hematocrit, and platelet counts within 180 days of the prior authorization request?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
17. Is the patient or their partner of childbearing age?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, skip to question 19.]	
18. Is the patient utilizing 2 forms of contraception for the duration of therapy, as well as for 6 months post-treatment?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
19. Is the patient human immunodeficiency virus (HIV) positive?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, skip to question 21.]	
20. Has the patient's current antiretroviral regimen and degree of viral suppression been documented within 180 days prior to the request?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
21. Does the patient have active hepatitis B virus (HBV) disease?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, skip to question 23.]	
22. Has the patient's current antiretroviral regimen and degree of viral suppression been documented within 180 days prior to the request?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	

[If no, no further questions.]	
23. Has a treatment plan been developed and discussed with the patient?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
24. Does the patient have a contraindication to the preferred agent (Mavyret) or a medical condition/diagnosis that precludes the use of the preferred agent (Mavyret)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
25. Has the patient previously been treated with velpatasvir and sofosbuvir?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
26. Is the patient 3 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
27. Does the patient have a HCV genotype of genotype 1, 2, 3, 4, 5, or 6?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
28. Is the patient treatment naive or experienced and meet any of the following: A) no cirrhosis, OR B) compensated cirrhosis (Child-Pugh A)?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, skip to question 30.]	
29. Does the patient have decompensated cirrhosis (Child-Pugh B and C)?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
30. Is the requested duration of therapy greater than 12 weeks?	<input type="checkbox"/> Y <input type="checkbox"/> N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

<b>Prescriber (Or Authorized) Signature and Date</b>