

Prior Authorization
JOHNS HOPKINS HEALTH PLANS (MEDICAID) Eclusa - Priority Partners MCO 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 1-410-424-4607 . Please contact Johns Hopkins Health Plans at 1-888-819-1043 with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Eclusa - Priority Partners MCO.

Drug Name (select from list of drugs shown) EPCLUSA (sofosbuvir/velpatasvir)

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:	_____

Diagnosis: _____	ICD Code: _____
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Comments: _____

Please circle the appropriate answer for each question.	
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'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.]	

3. 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.]	
4. 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 7.]	
5. Has clinical documentation showing support for the diagnosis, prior hepatitis C treatment history, and 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.]	
6. Does the patient have baseline laboratory values including HCV RNA level within 90 days of prior authorization request?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 9.]	
[If no, no further questions.]	
7. Has clinical documentation showing support for the diagnosis, prior hepatitis C treatment history, and 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.]	
8. Does the patient have baseline laboratory values including 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.]	
9. Is the patient HIV positive?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, skip to question 11.]	
10. 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.]	
11. Does the patient have active HBV disease?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, skip to question 13.]	
12. 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.]	
13. Has the consult been performed and medication prescribed by a provider specializing in infectious disease, gastroenterology, hepatology or Hepatitis C?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
14. Has a treatment plan been developed for the patient in collaboration with a physician with expertise in Hepatitis C management?	<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 18.]	
16. Is the patient or their partner of childbearing age?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, skip to question 18.]	
17. Is she 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.]	
18. 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.]	
19. Will the patient be prescribed more than one 100mg/400mg tablet per day (28 tablets/28 days)?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
20. Is the patient treatment naive to therapy with velpatasvir and sofosbuvir?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
21. Is the patient 18 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
22. 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.]	
23. Does the patient 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 26.]	
24. Does the patient have decompensated cirrhosis (Child-Pugh B and C)?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
25. Will the requested regimen contain weight-based ribavirin?	<input type="checkbox"/> Y <input type="checkbox"/> N

[If no, no further questions.]	
26. Is the requested duration of therapy greater than 12 weeks?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
27. Will HCV RNA level be obtained between treatment weeks 2-4 for continuation of treatment?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required for continuation of treatment beyond 8 weeks.	

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.

Prescriber (Or Authorized) Signature and Date