PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS

Harvoni - 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 Harvoni - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Harvoni (ledipasvir/sofosbuvir)

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:** _____

Comments: _____

Please circle the appropriate answer for each question.

1.	Does the patient have a diagnosis of chronic hepatitis C?	Y 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?	Y 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)?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
4.	Has the patient's genotype and subtype been determined?	Y 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?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
6.	Does the patient have a diagnosis of cirrhosis?	Y 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?	Y 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, total bilirubin, albumin, and INR within 90 days of prior authorization request?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
9.	Has the patient been prescribed a ribavirin-containing regimen?	Y 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?	Y N
	[If no, no further questions.]	
11.	Is the patient or their partner of childbearing age?	Y 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?	Y 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 planned treatment been submitted and dated within 180 days of the prior authorization request?	Y 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?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
15. Has the patient been prescribed a ribavirin-containing regimen?	Y 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?	Y N	
[If no, no further questions.]		
17. Is the patient or their partner of childbearing age?	Y 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?	Y N	
[If no, no further questions.]		
19. Is the patient human immunodeficiency virus (HIV) positive?	Y 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?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
21. Does the patient have active hepatitis B virus (HBV) disease?	Y 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?	Y 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?	Y 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)?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
25. Will the patient use ledipasvir/sofosbuvir and P-gp inducers (e.g., rifampin, St. John's Wort) concomitantly?	Y N
[If yes, no further questions.]	
26. Has the patient previously been treated with ledipasvir and sofosbuvir?	Y N
[If yes, no further questions.]	
27. Is the patient 3 years of age or older?	Y N
[If no, no further questions.]	
28. Does the patient have a HCV genotype of genotype 1?	Y N
[If no, skip to question 33.]	
29. Is the patient treatment naive?	Y N
[If no, skip to question 31.]	
30. Does the patient meet any of the following: A) no cirrhosis B) compensated cirrhosis (Child Pugh A), C) decompensated cirrhosis (Child-Pugh B or C) and will also take ribavirin, or D) is a liver transplant recipient without cirrhosis, or with compensated cirrhosis (Child-Pugh A) and will also take ribavirin?	Y N
[If yes, skip to question 38.]	
[If no, no further questions.]	
31. Does the treatment-experienced patient meet any of the following: A) no cirrhosis, B) decompensated cirrhosis (Child-Pugh B or C) and will also take ribavirin, or C) is a liver transplant recipient without cirrhosis, or with compensated cirrhosis (Child-Pugh A) and will also take ribavirin?	Y N
[If yes, skip to question 38.]	
32. Does the treatment-experienced patient have compensated cirrhosis (Child Pugh A)?	Y N
[If yes, skip to question 39.]	
[If no, no further questions.]	
33. Does the patient have a HCV genotype of 4?	Y N
[If no, skip to question 36.]	

34. Is the patient treatment-naive or treatment experienced, and a liver transplant recipient without cirrhosis, or with compensated cirrhosis (Child-Pugh A) who will be taking ribavirin?	Y N
[If yes, skip to question 38.]	
35. Is the patient treatment-naive or treatment experienced and meets either of the following: A) no cirrhosis or B) compensated cirrhosis (Child Pugh A)?	Y N
[If yes, skip to question 38.]	
[If no, no further questions.]	
36. Does the patient have a HCV genotype of genotype 5, or 6?	Y N
[If no, no further questions.]	
37. Is the patient treatment-naive or treatment experienced and meets either of the following: A) no cirrhosis or B) compensated cirrhosis (Child Pugh A)?	Y N
[If no, no further questions.]	
38. Is the requested duration of therapy greater than 12 weeks of treatment?	Y N
[No further questions.]	
39. Is the requested duration of therapy greater than 24 weeks of treatment?	Y 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.

Prescriber (Or Authorized) Signature and Date