



<b>Prior Authorization</b>
<p><b>JOHNS HOPKINS HEALTH PLANS</b>          Zepatier - 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 Zepatier - Priority Partners MCO.</p>

Drug Name (select from list of drugs shown) Zepatier (elbasvir/grazoprevir)
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Quantity	Frequency	Strength
Route of Administration	Expected Length of Therapy	

<b>Patient Information</b>	
Patient Name:	_____
Patient ID:	_____
Patient Group No.:	_____
Patient DOB:	_____
Patient Phone:	_____

<b>Prescribing Physician</b>	
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 14.]	
7. Does the patient have decompensated cirrhosis (Child-Pugh B or C)?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
8. 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.]	
9. Does the patient have baseline laboratory values including HCV RNA level, total bilirubin, albumin, and INR 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.]	
10. Has the patient been prescribed a ribavirin-containing regimen?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, skip to question 12.]	
11. 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.]	
12. Is the patient or their partner of childbearing age?	<input type="checkbox"/> Y <input type="checkbox"/> N

[If no, skip to question 20.]	
13. 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 yes, skip to question 20.]	
[If no, no further questions.]	
14. 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.]	
15. 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.]	
16. Has the patient been prescribed a ribavirin-containing regimen?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, skip to question 18.]	
17. 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.]	
18. Is the patient or their partner of childbearing age?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, skip to question 20.]	
19. 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.]	
20. Is the patient human immunodeficiency virus (HIV) positive?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, skip to question 22.]	
21. 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.]	
22. Does the patient have active hepatitis B virus (HBV) disease?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, skip to question 24.]	

23. 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.]	
24. Has a treatment plan been developed and discussed with the patient?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
25. 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.]	
26. Has genotype testing for baseline NS5A polymorphisms been performed for the patient?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
27. Is the patient 12 years of age or older and weigh at least 30 kg?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
28. Has the patient previously been treated with elbasvir and grazoprevir?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
29. Does the patient have a HCV genotype of genotype 1A?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, skip to question 34.]	
30. Is the patient treatment-naïve or Peginterferon alfa + ribavirin experienced, WITHOUT baseline NS5A polymorphisms?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, skip to question 38.]	
31. Is the patient treatment-naïve, or Peginterferon alfa + ribavirin experienced, WITH baseline NS5A polymorphisms?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, skip to question 33.]	
32. Is the requested duration of therapy greater than 16 weeks?	<input type="checkbox"/> Y <input type="checkbox"/> N
[No further questions.]	
33. Has the patient previously been treated with a Peginterferon alfa + ribavirin + HCV NS3/4A protease inhibitor regimen?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, skip to question 38.]	
[If no, no further questions.]	
34. Does the patient have a HCV genotype of genotype 1B?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, skip to question 36.]	

35. Is the patient treatment-naive, Peginterferon alfa + ribavirin experienced, or Peginterferon alfa + ribavirin + HCV NS3/4A protease inhibitor experienced?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, skip to question 38.]	
[If no, no further questions.]	
36. Does the patient have a HCV genotype of genotype 4?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
37. Is the patient treatment naive?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, skip to question 39.]	
38. Is the requested duration of therapy greater than 12 weeks?	<input type="checkbox"/> Y <input type="checkbox"/> N
[No further questions.]	
39. Has the treatment experienced patient had prior trial and failure with Peginterferon alfa + ribavirin?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
40. Is the requested duration of therapy greater than 16 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>