Priority Partners MCO
7231 Parkway Drive, Suite 100
Hanover, MD 21076

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Prior Authorization

JOHNS HOPKINS HEALTHCARE (MEDICAID)

Epclusa - 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 Healthcare at **1-410-424-4607**.
Please contact Johns Hopkins Healthcare at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Epclusa - 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:** _____

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's genotype and subtype been determined? Y 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?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
4. Does the patient have a diagnosis of cirrhosis?	Y 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?	Y 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?	Y 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?	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 within 180 days of prior authorization request?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
9. Is the patient HIV positive?	Y 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?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
11. Does the patient have active HBV disease?	Y 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?	Y 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?	Y 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?	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 18.]		
16. Is the patient or their partner of childbearing age?	Y 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?	Y 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)?	Y 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)?	Y N	
[If yes, no further questions.]		
20. Is the patient treatment naive to therapy with velpatasvir and sofosbuvir?	Y N	
[If no, no further questions.]		
21. Is the patient 18 years of age or older?	Y N	
[If no, no further questions.]		
22. Does the patient have a HCV genotype of genotype 1, 2, 3, 4, 5, or 6?	Y 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)?	Y N	
[If yes, skip to question 26.]		
24. Does the patient have decompensated cirrhosis (Child-Pugh B and C)?	Y N	
[If no, no further questions.]		
25. Will the requested regimen contain weight-based ribavirin?	Y N	

	[If no, no further questions.]
26.	Is the requested duration of therapy greater than 12 weeks? Y N
	[If yes, no further questions.]
27.	Will HCV RNA level be obtained between treatment weeks 2-4 for continuation of treatment? Y 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