GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Please note: All information below is required to process this request.
Mon-Fri: 8am to 1am Eastern / Sat: 9am to 6pm Eastern

Hepatitis C Virus (HCV) Re-Treatment Prior Authorization Request Form (Page 1 of 2)

Note: If the following information is incomplete, incorrect, or illegible, the PA process can be delayed.
Please complete a form for each member.

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength: / Dosage Form:
❑ Check if requesting **brand**	Directions for Use:
❑ Check if request is for **continuation of therapy**	

Clinical Information (required)

Select the medication being requested:
❑ Sovaldi ❑ Epclusa ❑ Harvoni ❑ Mavyret ❑ Ribavirin ❑ Zepatier

❑ Other:_____

Clinical information:
Select the duration of therapy requested: ❑ 8 weeks ❑ 12 weeks ❑ 24 weeks ❑ Other: _____
What is the pretreatment viral load (HCV RNA)? _____ IU/mL Date: _____
What is the HCV viral genotype? ❑ 1a ❑ 1b ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6
Is the genotype different from the initial treatment? ❑ **Yes** ❑ **No** Specify: _____
Does the patient have cirrhosis? ❑ **No** **Yes:** ❑ Compensated ❑ Decompensated
Which regimen was the patient <u>previously treated</u> with (check all that apply)?
❑ Daklinza ❑ Epclusa ❑ Harvoni ❑ Olysio ❑ Ribavirin ❑ Mavyret
❑ Sovaldi ❑ Technivie ❑ Viekira Pak ❑ Viekira XR ❑ Zepatier ❑ Vosevi

❑ Other:_____
Did patient complete therapy with this previous regimen? ❑ **Yes** ❑ **No**
If **Yes** to the above, how many weeks of therapy did the patient receive? _____ weeks
If the patient did <u>not</u> complete therapy, specify the reason for incomplete therapy: _____
_____
_____
_____
What was the outcome of treatment? ❑ Partial Response ❑ No Response ❑ Relapse
Did the patient fail previous therapy or relapse due to intravenous substance abuse? ❑ **Yes** ❑ **No**
Did patient fail previous therapy due to noncompliance with the prescribed regimen? ❑ **Yes** ❑ **No**
Did the patient fail therapy due to side effects? ❑ **Yes** ❑ **No**
If **Yes** to the above, specify the side effects: _____
_____
Has the patient received a liver transplant? ❑ **Yes** ❑ **No**
If **Yes** to the above, specify the date: _____
Is the patient awaiting a liver transplant? ❑ **Yes** ❑ **No**
Are NS5A or NS3 polymorphisms present? ❑ No ❑ NS5A ❑ NS3 Date of Test: _____

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Hepatitis C Virus (HCV) Re-Treatment Prior Authorization Request Form (Page 2 of 2)

In the space below, provide any additional information deemed clinically relevant in evaluating the prior authorization request. A separate letter of medical necessity (LOMN) may also be attached.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Physician Signature: _____ **Date**:_____

Contact Person: _____ **Phone**: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-866-525-5827.
This form may be used for non-urgent requests and faxed to 1-888-491-9742.