aetna®

Hepatitis C Treatment Medication Precertification Request

(Please complete all fields and return both pages for precertification of medications.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment ☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ Hepatologist ☐ Infectious Disease ☐ Gastroenterologist ☐ Primary Care ☐ Other: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
Address: _____
☐ Administration code(s) (CPT): _____

Dispensing Provider/Pharmacy: *(Patient selected choice)*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: *(Check all that apply)*

Please select if patient is new to therapy or continuation of therapy. **If continuation of therapy, indicate the initial start date** and requested duration of therapy.

Medication	Dose/Frequency	New therapy	Continuation	Initial start date	Duration of therapy
☐ **Daklinza** (daclatasvir) *28 day supply limit		☐	☐	____/____/____	
☐ **Epclusa** (velpatasvir/ sofosbuvir) *28 day supply limit		☐	☐	____/____/____	
☐ **Harvoni** (ledipasvir/sofosbuvir) *28 day supply limit		☐	☐	____/____/____	
☐ **Intron-A** (interferon alfa-2b)		☐	☐	____/____/____	
☐ **Mavyret** (glecaprevir/pibrentasvir) *28 day supply limit		☐	☐	____/____/____	
☐ **Olysio** (simeprevir) *28 day supply limit		☐	☐	____/____/____	
☐ **Pegasys** (pegylated interferon alfa-2a)		☐	☐	____/____/____	
☐ **PEG-Intron** (pegylated interferon alfa-2b)		☐	☐	____/____/____	
☐ **Ribavirin**		☐	☐	____/____/____	
☐ **Sovaldi** (sofosbuvir) *28 day supply limit		☐	☐	____/____/____	
☐ **Technivie** (ombitasvir/paritaprevir/ ritonavir) *28 day supply limit		☐	☐	____/____/____	
☐ **Viekira Pak or** ☐ **Viekira XR** (ombitasvir/paritaprevir/ ritonavir/ dasabuvir) *28 day supply limit		☐	☐	____/____/____	
☐ **Vosevi** (sofosbuvir/velpatasvir/voxilaprevir) *28 day supply limit		☐	☐	____/____/____	
☐ **Zepatier** (elbasvir/grazoprevir) *28 day supply limit		☐	☐	____/____/____	

☐ **Other** (Please specify) _____

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F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION *[Section 1]*

For Initiation of therapy: Must submit medical records documenting HCV and genotype with subtype, if applicable (i.e., genotype 1a, 1b)

What is the pretreatment viral load (HCV RNA) and date? *Results within past 6 months Viral Load: _____IU/mL Date: ____/____/____

What is the viral genotype? ***Check one*** - Hepatitis C genotype**:** ☐ **1a** ☐ **1b** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** Other (specify): _____

For Continuation of therapy ALL patients: Please note- if the patient is NEW to Aetna please complete all questions in sections G and H.

Please indicate start date of treatment: Date: ____/____/____

****Viral load required to be submitted by prescriber at 12 weeks after completion of therapy****

☐ Yes ☐ No Is the patient new to Aetna? If yes, please indicate previous carrier. _____

What was the pretreatment viral load (HCV RNA) and date? Viral Load: _____IU/mL Date: ____/____/____

☐ Yes ☐ No Has the patient been on therapy for greater than 4 weeks?

What is the 4 week viral load (HCV RNA) and date of test? Viral Load: _____IU/mL Date: ____/____/____

What is the viral genotype? ***Check one*** - Hepatitis C genotype**:** ☐ **1a** ☐ **1b** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** Other (specify): _____

H. CLINICAL INFORMATION *[Section 2] *Required for all Initiations of therapy and for Continuation of therapy if new to Aetna*

Which of the following testing has the patient had completed in order to determine liver stage?

☐ Liver biopsy ☐ Metavir ☐ Fibroscan ☐ FibroTest-ActiTest ☐ Fibrosure ☐ APRI ☐ SWEI ☐ Other: _____

What were the results? _____

****Must submit medical records for any ONE of the above tests or radiological imaging, physical findings or clinical evidence consistent with cirrhosis as attested by the prescribing physician**.

☐ Yes ☐ No Does the patient have cirrhosis**?

☐ Yes ☐ No Does the patient have decompensated liver disease (Child Pugh score greater than 6)? **If yes**, please provide score: _____

☐ Yes ☐ No Will the patient be taking Ribavirin with the requested regimen?

☐ Yes ☐ No Has the patient received a liver transplant?

☐ Yes ☐ No Has the patient had a solid organ transplant other than liver (heart, lung), if so, what type _____

☐ Yes ☐ No Does the patient have documented hepatocellular carcinoma?

☐ Yes ☐ No Is the patient awaiting a liver transplant?

☐ Yes ☐ No Does the patient have HCV/HIV-1 co-infection?

☐ Yes ☐ No Does the patient have HCV/HBV co-infection?

Please indicate the patient's creatinine clearance (CrCl) or eGFR: _____mL/min Date taken: _____

☐ Yes ☐ No Does the patient have End Stage Renal Disease?

→ ☐ Yes ☐ No Is the patient currently receiving dialysis (hemodialysis or peritoneal dialysis)?

☐ Yes ☐ No Is the patient treatment experienced? ***If yes***, please indicate all previous medications used: ☐ Daklinza ☐ Epclusa ☐ Harvoni

→ ☐ IFN ☐ Mavyret ☐ RBV ☐ Olysio ☐ Sovaldi ☐ Technivie ☐ Viekira Pak ☐ Viekira XR ☐ Vosevi ☐ Zepatier

☐ Other: _____

Please indicate previous regimens response: ☐ Null ☐ Partial ☐ Relapse

☐ Yes ☐ No ☐ N/A If the previous regimen contained a direct acting agent (DAA), was a resistance profile completed?

→ Please provide the results: _____

☐ Yes ☐ No Was previous treatment completed?

→ Please explain the rationale for not completing treatment: _____

→ Please indicate how many weeks of therapy the patient was able to complete: _____

☐ Yes ☐ No Is the patient being treated due to reinfection?

→ Was resistance testing completed for NS5A polymorphisms? ***If yes***, please provide results: _____

☐ Yes ☐ No Is the patient ribavirin intolerant/ineligible? ***Medical documentation and/or lab results are required for anything checked below.***

→ Please indicate all that apply:

- ☐ Platelets <50 000 cells/mm3 results within the past month
- ☐ Autoimmune hepatitis or other autoimmune condition known to be exacerbated by ribavirin
- ☐ Known hypersensitivity to drugs used to treat HCV
- ☐ Neutrophils <750 cells/mm^3 results within the past month
- ☐ Hemoglobin < 10g/dL results within the past month
- ☐ Other: Please explain: _____

☐ Yes ☐ No Does the patient have a contraindication or intolerance to any of the ingredients in Epclusa, Harvoni, Sovaldi, Vosevi or Zepatier?

→ Please explain: _____

For all Daklinza or Zepatier genotype 1a requests:

☐ Yes ☐ No Does the patient have NS5A polymorphism (amino acid positions 28, 30, 31, or 93)? Date of test: _____

For all Daklinza genotype 3 requests:

☐ Yes ☐ No Does the patient have NS5A polymorphism amino acid position 93? Date of test: _____

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I. ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*: _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.