MEDICATION PRIOR AUTHORIZATION REQUEST FORM

FAX this completed form to 1-888-865-6531

OR Mail request to: Envolve Pharmacy Solutions Prior Authorization Dept.

5 River Park Place East, Suite 210 | Fresno, CA 93720

Call 1-833-705-1351 to request a 72-hour supply of medication.

Envolve Pharmacy Solutions will respond via fax or phone within 24 hours of receipt of all necessary information, except during weekends and holidays. For immediate response on weekends and holidays, NurseWise will answer your call.



HEPATITIS C AGENTS

Note: Form must be completed in full. An incomplete form may be returned.



| Recipient's Medicaid ID# Date of E | Date of Birth (MM/DD/YYYY) | | | | | | | | | | |
|---|-------------------------------|-----------|---------|--------|----------|---------|--------|-----------|-------|-------|--------|
| | 1 | | 1 | | | | | | | | |
| Recipient's Full Name |] [| | | | | | | | | | |
| | | | | | | | | | | | |
| Prescriber's Full Name | <u> </u> | | | l l | <u> </u> | | 1 1 | | | | |
| Trescriber 3 turi Name | | | | | | | | | | | |
| Prescriber's NPI | | | | | | | | | | | |
| Prescriber's NPT | | | | | | | | | | | |
| Described Blows New Low | | | D | | | N | | | | | |
| Prescriber's Phone Number | | | Pres | cribe | | x Nun | iber | | | | |
| | | | | | | - | | _ | | | |
| Preferred Agents: Mavyret™, sofosbuvir/velpatasv | ir (gen | eric Ep | clusa | a®), a | nd V | osev/ | i® (re | treatm | ent r | ecip | ients) |
| (If prescribing non-preferred alternatives, please provide doc | cument | ation of | medica | al rea | son(s | s) why | the pa | atient is | unab | le to | take a |
| preferred medication.) | | | | | | | | | | | |
| What is the requested medication? (Include strength, di | rection | s, quan | tity, a | nd dı | ıratic | on of t | herap | y.) | | | |
| | | | | | | | | | | | |
| Physician must submit all supporting documentation in | cluding | g lab res | ults. | | | | | | | | |
| Does the recipient have chronic hepatitis C? (Submit supportir | it supporting documentation.) | | | | | | | | | | ☐ No |
| If YES, indicate the stage of fibrosis: | _ | | , | | | | | | | | |
| 2. What is the recipient's HCV genotype? (attach genotype test r | esults) | |] 1a | ☐ 1b | |] 2 | □ 3 | ☐ 4 | | 5 | □ 6 |
| Has the recipient been previously treated with HCV therapy? | | | | | | | | ☐ Ye | 10 | | □ No |
| If <i>YES</i> , please specify date, treatment regimen, and duration: | | | | | | | | | | | |
| If YES, please document response to therapy: Null responder Partial responder | | | | | | | | | | r | |
| 4. Does the recipient have chronic HCV with cirrhosis? (Supporting documentation required.) | | | | | | | | | | | ☐ No |
| If cirrhosis, what type? | _ | | = | |] Dec | ompen | sated | ☐ Ye | - | | |
| | | | | | | • | | | | | |
| 5. Child-Pugh Score: (Submit supporting documentation.) | | | | | | | | ΙIΑ | 1.7 | В | Пс |

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HEPATITIS C AGENTS

Note: Form must be completed in full. An incomplete form may be returned.



| Rec | ipier | nt's | Full | Name | е | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|------------------------------------|-------|--------|----|--------|------|------|-------|-------|-------|-------|--|------|------------|------------|------|------|----|--------|-----|------|--|--|--|--|--|--|--|
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. | 6. Has the patient recently been tested for Hepatitis B Virus infection? (Current lab work must be included.) | | | | | | | | | | | | | | Δ, | Yes | ; | □ No | | | | | | | | | | | |
| 7. | 7. Does the recipient have hepatocellular carcinoma? | | | | | | | | | | | | | | Yes | į | ☐ No | | | | | | | | | | | | |
| 8. | 8. Is the recipient HIV co-infected? (Must have documented diagnosis and must submit most recent CD4 count – within last 6 months.) | | | | | | | | | | | ☐ Yes | | | i | ☐ No | | | | | | | | | | | | | |
| 9. | 9. Liver transplant? (If YES, please specify date and submit supporting documentation.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Await | ing li | ve | r trar | nspl | lant | (date |): | | | | | |] No | |] P | os | t-trar | spl | lant | | | | | | | |
| 10. | 10. Indicate HCV RNA level: (Must submit lab results within the past six months for baseline.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Treatment week Log10 Date Measured | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Pi | re-treatment baseline | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11. Has the recipient committed to the documented planned course of treatment, inclusive of anticipated blood tests and physician visits, during and after treatment? | | | | | | | | | | Yes | | | | ☐ No | | | | | | | | | | | | | | | |
| 12. | 12. For ribavirin therapy: If the patient is a female of childbearing potential, has a negative pregnancy test within 30 days of initiating therapy been submitted? | | | | | | | | | | ☐ Yes | | | | ☐ No | | | | | | | | | | | | | | |
| 13. Has recipient abstained from illicit drugs and/or alcohol consumption for a minimum of 1 month? (Must submit results of test.) | | | | | | | | | | Yes | | | | | ☐ No | | | | | | | | | | | | | | |
| | OR | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. Is the recipient receiving substance or alcohol abuse counseling services? (Must submit supporting documentation.) | | | | | | | | | | ☐ Yes | | | | |] No | | | | | | | | | | | | | | |
| By signing below, the prescriber attests that all statements provided are accurate. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Prescriber's Signature: Date: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes) and the most recent copies of related labs. The provider must retain copies of all documentation for five years. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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