Physician Request Form for Hepatitis C Therapies

Select Health of South Carolina
Healthy Connections

Fax to PerformRx at **1-866-610-2775**, or call **1-866-610-2773** to speak to a representative.

All information on this form must be completed for processing.

Patient name:			Patient ID:
Patient address:			Date of birth:
City:	State:	ZIP:	Weight:
Prescriber name:			NPI:
Prescriber address:			Phone:
City:	State:	ZIP:	Fax:
Contact name:			
Prescriber specialty: ☐ Hepatology ☐ Gastroenterology ☐ Infectious disease ☐ Transplant ☐ HIV			
Requested regimen*, dose, and duration:____________________________________ *Preferred agents: Mavyret, Epclusa (generic), or Harvoni (generic)			

Provider attests to all of the following:

- Member has a limited life expectancy due to non-liver related comorbid condition (less than 12 months): ☐ Yes ☐ No
- Member has been screened for hepatitis B (HBV) and human immunodeficiency virus (HIV): ☐ Yes ☐ No
  Patient is infected with HBV? ☐ Yes ☐ No Patient is infected with HIV? ☐ Yes ☐ No
- All potential drug interactions with concomitant medications have been addressed: ☐ Yes ☐ No
- Does the member currently have issues with compliance? ☐ Yes ☐ No
- Provider attests that member has been counseled on barriers to hepatitis C therapy, alcohol, and illicit drug use: ☐ Yes ☐ No
- Provider attests that the member is committed to the treatment plan, including lab monitoring at four, eight, and 12 weeks, and SVR12 lab testing will be completed and submitted to health plan: ☐ Yes ☐ No
- Member's previous treatment history and response: ____________________________________
- Member completed treatment: ☐ Yes ☐ No
- Is the member cirrhotic? ☐ Yes* ☐ No
  *If **Yes**, provide Child Turcotte Pugh Class: ☐ Class A ☐ Class B ☐ Class C
- Does member have hepatocellular carcinoma? ☐ Yes* ☐ No
  - *If **Yes**, confirmation of diagnosis was made by ultrasound, tomography, MRI, laparoscopy, or biopsy: ☐ Yes ☐ No

Member has *one* of the following: (All applicable documentation must be included with this request.)

- History of liver transplant: ☐ Yes* ☐ No *If **Yes**, date of transplant: ________________
- Is HIV or HBV coinfected: ☐ Yes ☐ No
- Serious extrahepatic manifestations of hepatitis C: ☐ Yes ☐ No

Lab testing required (attach copy of results):

- **Genotype** (with subtype if provided) ___________________________
- **RASs testing as indicated in guidelines** (resistance-associated substitutions, previously called RAVs)

Copies of the following lab testing results (completed within three months of starting therapy) *must* be submitted with request:

- **Detectable HCV RNA viral load**
- **GFR**
- **ALT/AST**
- **INR**
- **TSH** (**only** if regimen contains interferon)
- **CBC** (**only** if regimen contains ribavirin)
- **Pregnancy test** (within one month and **only** if regimen contains ribavirin and the member is of child-bearing age)

Provider signature:	Date:

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