Physician Request Form for Hepatitis C Therapies
Fax to Pharmacy Services at **855-452-9131**, or call **800-684-5502**
to speak to a representative. ***Form must be completed for processing***.

AmeriHealth Caritas Louisiana

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
☐Other_____

Requested Regimen, Dose and Duration: _____

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
- Is the member actively abusing drugs and/or alcohol? ☐Yes ☐No
- Provider attests that the member is committed to the treatment plan, including lab monitoring 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 attests to the following:

- That he/she is not actively abusing drugs and/or alcohol: ☐Yes ☐No

Member has ONE of the following: (<u>All applicable documentation must be included with this request</u>)

- History of liver transplant: ☐Yes* ☐No *If Yes, date of transplant: _____
- Is HIV or HBV co-infected: ☐Yes ☐No
- Serious extrahepatic manifestations of Hepatitis C: ☐Yes ☐No
- A Metavir fibrosis score of F3-F4 documented by liver biopsy, FibroSure/FibroTest or with sheer wave elastography **(copy of result REQUIRED)**:
  ☐Yes ☐No Fibrosis Level: _____
- Physical findings consistent with substantial or advanced fibrosis: ☐Yes ☐No

Lab testing required (<u>attach copy of results</u>):

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

Copies of the following lab testing results (<u>completed within 3 months of starting therapy</u>) MUST be submitted with request:

- **Detectable HCV RNA viral load**
- **ALT/AST**
- **TSH** (ONLY if regimen contains interferon)
- **GFR**
- **INR**
- **CBC** (ONLY if regimen contains ribavirin)

Copies of the following lab testing results (<u>completed within 1 month of starting therapy</u>) MUST be submitted with request:

- **Pregnancy test** (**within 1 month** and ONLY if regimen contains ribavirin and the member is of child bearing age)

Prescriber Signature: _____ **Print Name:** _____ **Date**: _____