Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Sofosbuvir-Velpatasvir - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: ☐ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval. Please answer the following questions and sign.

Q1. Is the patient 3 years of age or older?

☐ Yes ☐ No

Q2. Does the patient have a diagnosis of chronic hepatitis C with supporting documentation?

☐ Yes ☐ No

Q3. Are the following baseline labs attached?
A. HCV genotype and subtype
B. Quantitative HCV RNA
C. Complete blood count (CBC)
D. International normalized ratio (INR)
E. Hepatic function panel (albumin, total and direct bilirubin, alanine aminotransferase, aspartate aminotransferase, and alkaline phosphatase levels)
F. Serum creatinine/calculated glomerular filtration rate
G. Transient elastography (such as FibroScan) or noninvasive serologic tests (such as FibroSure)
H. Hepatitis B surface antigen (HBsAg), Hepatitis B core antibody (anti-HBc), Hepatitis B surface antibody (anti-HBs)
I. HIV antigen/antibody test

☐ Yes ☐ No

Q4. Does the patient have any conditions that would fall under the exclusion criteria per AASLD guidance?

☐ Yes ☐ No

Q5. Additional Information:

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

Q6. Requested Duration:

☐ 12 Weeks ☐ 24 Weeks

Prescriber Signature

Date

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document