

HEPATITIS C PROTEASE INHIBITORS VICTRELIS and INCIVEK Prior Authorization Form

*Please note: Interferon products for Hepatitis C also require prior authorization. Please complete appropriate form.
(Please be sure to complete and include the 2nd page of this form)*

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services. Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE 800-979-UPMC (8762)

FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY

. Incomplete responses may delay this request.

Office Contact:	Provider Specialty:
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Provider First Name:	Provider Last Name:
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Provider Phone:	Provider Fax:	Provider NPI #:
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Patient Name:	Patient UPMC Health Plan ID Number:	Patient DOB:	Patient Age
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Drug Requested: <input type="checkbox"/> Victrelis (boceprevir) <input type="checkbox"/> Incivek (telaprevir)	Strength:	Frequency:	Length of Treatment:
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<input type="checkbox"/> New Medication	If Ongoing, Please provide date started:	If medication is ongoing, did the member show improvement while on therapy on? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

Please indicate place of infusion: <input type="checkbox"/> Physician Office <input type="checkbox"/> Hospital/Facility <input type="checkbox"/> Patient Home Please provide facility/provider name and address:	Please indicate how drug will be billed: <input type="checkbox"/> Billed directly by the provider via JCODE. Provide JCODE: _____ <input type="checkbox"/> Billed by a pharmacy and delivered to the provider <input type="checkbox"/> Billed by a pharmacy and delivered to the patient
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Medical History

Does the member have a diagnosis of chronic Hepatitis C? Yes No

If no, please indicate diagnosis: _____

Please indicate genotype: _____

Will the member be taking the requested protease inhibitor in combination with peginterferon alfa and ribavirin? Yes No

Has the member been previously treated with peginterferon and ribavirin therapy? Yes No

If yes, please indicate response to peginterferon and ribavirin therapy: (please provide dates of therapy)

Relapser.....Please provide dates of therapy _____

Partial Responder.....Please provide dates of therapy _____

Null Responder.....Please provide dates of therapy _____

Please indicate intended start date of therapy with the requested protease inhibitor: _____

Has the member been previously treated either with Victrelis (boceprevir) or Incivek (telaprevir)? Yes No

Please be sure to complete and include the 2nd page of this form

VICTRELIS and INCIVEK

Page 2

Patient Name	Patient UPMC Health Plan ID Number:	Patient DOB:
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Please be sure to complete and include this page with the 1st page of this form

Please provide quantitative hepatitis C virus titers (HCV RNA) for the following time points in the current course of therapy:

Date of HCV RNA test	HCV RNA Result	Please attach chart documentation of HCV RNA results showing date, reference range, and assay.
<input type="checkbox"/> Baseline:		<input type="checkbox"/> Chart documentation enclosed <i>*Note: assay used to determine HCV RNA levels must have a lower limit of HCV-RNA quantification of ≤ 25 IU/ml and a limit of HCV-RNA detection of approximately 10-15 IU/ml*</i>
<input type="checkbox"/> Week 4:		
<input type="checkbox"/> Week 8:		
<input type="checkbox"/> Week 12:		
<input type="checkbox"/> Week 24:		

Does the member have compensated cirrhosis? Yes No

Does the member have any of the following illnesses or conditions? Please check all that apply.

- Autoimmune hepatitis
- Female members who are pregnant
- Male members whose female partners are pregnant
- Known hypersensitivity to drugs used to treat hepatitis C
- Decompensated liver disease

Please provide any additional information which should be considered in the space below: