Hepatitis C Medication Request Form

Today's date ___/___/___

To submit online, visit **point32health.promptpa.com** or send via mail to *Tufts Health Plan, 1 Wellness Way, Canton, MA 02021-1166, Attn: Pharmacy Utilization Management Department.*

THIS FORM CAN BE USED FOR THE FOLLOWING PLANS AND PRODUCTS:

Fax to 617.673.0956:

- ☐ Tufts Health Plan Medicare Preferred
- ☐ Tufts Health Plan Senior Care Options
- ☐ Tufts Health Unify

Member Information

Last name:	First name:
Member ID#:	Member DOB:

Prescriber Information

Prescribing Clinician:	Phone #:
Specialty (required):	Secure Fax #:
NPI #:	DEA/xDEA:
Prescriber Point of Contact Name (POC) (if different than provider):	
POC Phone #:	POC Secure Fax #:

Medication Information

Requested drug(s):

☐ Harvoni ☐ Viekira Pak ☐ Viekira XR ☐ Epclusa ☐ Sovaldi ☐ Technivie ☐ Vosevi ☐ Mavyret
☐ Zepatier ☐ Daklinza ☐ Ribavirin (generic) ☐ Ribavirin (Brand) ☐ Other:_____

Dose(s):_____ Requested Duration of Treatment:_____ weeks

Type of therapy: ☐ Initial ☐ Continuation - weeks remaining:_____ Anticipated start date:_____

Clinical Information

Diagnosis:
☐ B18.2 Hepatitis C (chronic)

HCV Genotype: ☐1a ☐1b ☐2 ☐3 ☐4 ☐5 ☐6

Stage of Hepatic Fibrosis: ☐F0 ☐F1 ☐F2 ☐F3 ☐F4

For members with early stage liver disease (Metavir Score F0-F2), please describe the medical necessity for requesting treatment at this time:

_____
_____
_____

Is the medication prescribed by a gastroenterologist, infectious disease specialist, or hepatologist?	☐ Yes	☐ No
Was the staging of hepatic fibrosis performed by a specialist through one of the following?	☐ Yes	☐ No

Please check all that apply and attach documentation including medical records and results of diagnostic tests: ☐ Liver biopsy confirming METAVIR score ☐ Transient elastography (Fibroscan) score ☐ Fibrotest (FibroSURE) score of greater ☐ Radiological imaging ☐ APRI score ☐ Physical findings or clinical evidence consistent with cirrhosis as attested by the prescriber		
Is there documented evidence of chronic liver disease, or in the absence of chronic liver disease, serologic evidence of persistent infection for at least six months?	☐ Yes	☐ No
Does the patient have HIV coinfection?	☐ Yes	☐ No
Has Hepatitis B screening been performed?	☐ Yes	☐ No
If patient has active Hepatitis B infection, has the risk of Hepatitis B reactivation been assessed? *Caution: FDA has warned about the risk of Hepatitis B reactivating in some patient treated with direct acting antiviral agents for Hepatitis C. AASLD recommends treating Hepatitis B concurrently or prior to Hepatitis C treatment.*	☐ Yes	☐ No
Does the patient have severe renal impairment or end-stage renal disease, or require dialysis? Confirm the patient's GFR range: ☐ 0 – 14 ☐ 15 – 29 ☐ > / = 30	☐ Yes	☐ No
Has the patient been previously treated for Hepatitis C and failed treatment? *If yes, when?* _____*What treatment(s)?* _____ Response to treatment: ☐ Relapsed ☐ Partial response ☐ Null response (< 2 log reduction in HCV RNA at week 12) ☐ Did not complete Adverse reaction? ☐ Yes ☐ No	☐ Yes	☐ No
HCV RNA levels: Baseline within 6 months of beginning treatment (required): _____ IU/mL Date of lab work: _____ **Post-therapy** 12 weeks after completion of treatment: _____ IU/mL Date of lab work: _____		

Has there been confirmation that the patient does not have a genotype 1a with NS3 Q80K polymorphism? (Olysio only)	☐ Unknown	☐ Yes	☐ No
Has there been confirmation that the patient does not have a genotype 1a with a baseline NS5A polymorphism? (Zepatier only)	☐ Unknown	☐ Yes	☐ No
Will hepatic laboratory testing be performed prior to therapy, at treatment week 8, and as clinically indicated?		☐ Yes	☐ No
Does the patient have a diagnosis of hepatocellular carcinoma that meets Milan criteria?		☐ Yes	☐ No
If the patient require a dosage form other than ribavirin 200mg capsules or tablets, document clinical reason and provide dosage form. *Dosage form:*_____ *Clinical reason*: _____			
Are any of the following statements true? ☐ Patient is pregnant or is planning to become pregnant within 6 months after completion of treatment ☐ Patient is male with a female partner who is pregnant or is planning to become pregnant within 6 months after completion of treatment ☐ None of the above			
Is the member currently awaiting a liver transplant?		☐ Yes	☐ No
Does the member have cirrhosis? *If yes, please choose one:* ☐ Compensated (Child-Turcotte-Pugh Class A; no major complication of cirrhosis) ☐ Decompensated (Child-Turcotte-Pugh Class B or C)		☐ Yes	☐ No
Is the patient being managed in a liver transplant center?		☐ Yes	☐ No
Is the member actively participating in illicit substance abuse or alcohol abuse?		☐ Yes	☐ No
Is there documented attestation that the member has been assessed for potential nonadherence?		☐ Yes	☐ No

Is the member is receiving substance or alcohol abuse counseling services or seeing an addiction specialist as an adjunct to HCV treatment?	☐ Yes	☐ No
Has a treatment plan been developed and discussed with the patient?	☐ Yes	☐ No
Did the prescriber identify any potential issues with adherence? *If yes, please describe:* _____	☐ Yes	☐ No
Have drug interactions been reviewed and evaluated?	☐ Yes	☐ No

THIS SECTION APPLIES TO TUFTS HEALTH PLAN MEDICARE PREFERRED, TUFTS HEALTH PLAN SENIOR CARE OPTIONS and TUFTS HEALTH UNIFY only.

Does this member reside in long-term care? ☐ Yes ☐ No

Is the member enrolled in Hospice? ☐ Yes ☐ No If no, disenrollment date: _____

Is the drug related to the terminal illness or related conditions? ☐ Yes ☐ No

Provide an explanation of why the drug being prescribed is unrelated to the terminal illness/related conditions:

_____

_____

Is this a request for a formulary tier exception (the member's drug plan charges a higher copayment for the drug prescribed than it charges for another drug that treats the condition, and I want to pay the lower copayment – excludes nonformulary drugs and drugs on the specialty tier)? ☐ Yes* ☐ No

*If yes, a supporting statement from the prescribing physician is required. Please specify the request: (1) formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome

By checking the following box, I certify that applying the standard review time frame may seriously jeopardize my patient's life, health, or ability to attain, maintain, or regain maximum function. ☐ Request for expedited review

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____

Prescriber signature (STAMP NOT ACCEPTED) Date

TUFTS Health Plan

Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Tufts Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Tufts Health Plan at
1-800-701-9000 (HMO)/**1-866-623-0172** (PPO)/**(TTY: 711)**.

If you believe that Tufts Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with:

Tufts Health Plan, Attention:
Civil Rights Coordinator, Legal Dept.
1 Wellness Way, Canton, MA 02021
Phone: 1-888-880-8699 ext. 48000, (TTY: 711)
Fax: 1-617-972-9048
Email: OCRCoordinator@point32health.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Tufts Health Plan Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights; electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf; or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019 (TDD: 1-800-537-7697)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

thpmp.org | **1-800-701-9000** (HMO)/**1-866-623-0172** (PPO)/**(TTY: 711)**

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TUFTS Health Plan

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Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-701-9000 (HMO/PDP)/1-866-623-0172 (PPO). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-701-9000 (HMO/PDP)/1-866-623-0172 (PPO). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-701-9000 (HMO/PDP)/1-866-623-0172 (PPO)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-701-9000 (HMO/PDP)/1-866-623-0172 (PPO)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-701-9000 (HMO/PDP)/1-866-623-0172 (PPO). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-701-9000 (HMO/PDP)/1-866-623-0172 (PPO). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-701-9000 (HMO/PDP)/1-866-623-0172 (PPO) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-701-9000 (HMO/PDP)/1-866-623-0172 (PPO). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-701-9000 (HMO/PDP)/1-866-623-0172 (PPO)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-701-9000 (HMO/PDP)/1-866-623-0172 (PPO). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على **1-800-701-9000 (HMO/PDP)/1-866-623-0172 (PPO)** . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-701-9000 (HMO/PDP)/1-866-623-0172 (PPO) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-701-9000 (HMO/PDP)/1-866-623-0172 (PPO). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Português: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-701-9000 (HMO/PDP)/1-866-623-0172 (PPO). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-701-9000 (HMO/PDP)/1-866-623-0172 (PPO). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-701-9000 (HMO/PDP)/1-866-623-0172 (PPO). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サーービスがありますございます。通訳をご用命になるには、1-800-701-9000 (HMO/PDP)/1-866-623-0172 (PPO)にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

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