Neighborhood Health Plan OF RHODE ISLAND™

Hepatitis C Prior Authorization Form

Pharmacy Dept Phone: 1-401-427-8200
Fax: 1-866-423-0945

Instructions:

- Please complete and fax this prior authorization form along with all applicable documentation required directly to Neighborhood Health Plan of Rhode Island at 1-866-423-0945 for review.
- **Limited Specialty Pharmacy Network applies.**

Please fax prescription to one of the following 3 specialty pharmacies:

1. **Care New England Specialty Pharmacy** Phone: 855-981-1908 Fax: 401-889-5050
2. **CVS Specialty Pharmacy** Phone: 800-237-2767 Fax: 800-323-2445
3. **Lifespan Specialty Pharmacy** Phone: 401-444-9909 Fax: 401-444-4095

MEMBER INFORMATION		
Member's Name:	Member's ID Number:	Member's DOB:

PRESCRIPTION INFORMATION			
Medication Name/Strength	Directions	Quantity	Refills

PRESCRIBER INFORMATION

Prescriber's Name: ______________________________ Specialty: ________________________________

Address: ____

City: ____________________ State: ________________ Zip Code: __________

Phone #: ________________________________ Fax #: ____________________

Office Contact Name: ______________________ Prescriber's NPI #: ______________________

Prescriber's Signature Required: ____ Date: ________________

CLINICAL ASSESSMENT (Complete all requested information)	
Treatment Status:	❑ Treatment naïve ❑ Retreatment (prior treatment failure with another HCV agent) *If request is for Vosevi, no further information is required. ❑ Currently on therapy: Provide Start Date: ____________________
Provide previous Hepatitis C drug therapy (If applicable):	Drug(s): ______________________ Date(s): ____________________ ❑ Side effect ❑ Inadequate response ❑ Other: ____________________
Hepatitis C Genotype:	❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ Other: ________________
Hepatic Fibrosis Stage:	❑ Stage 0 ❑ Stage 1 ❑ Stage 2 ❑ Stage 3 ❑ Stage 4
Test used to determine disease stage (Check all that apply): Documentation must be submitted with PA request	❑ AST to Platelet Ratio Index (APRI) ❑ Fibroscan score ❑ Fibrotest score ❑ Imaging study ❑ Liver biopsy indicating METAVIR score ❑ Other, please specify: ____________________
Is cirrhosis present?	❑ Yes - If yes, ❑ Compensated Cirrhosis **OR** ❑ Decompensated Cirrhosis ❑ No
If requested, does the prescriber agree to submit post treatment viral load data?	❑ Yes ❑ No
Rationale as to why member is unable to use preferred HCV agents Mavyret and/or Vosevi. Clinical documentation must be provided.	