Prior Authorization Request
Nevada Medicaid – OptumRx

Hepatitis C Protease Inhibitors

Submit fax request to: 855-455-3303
Purpose: For a prescribing physician to request prior authorization for Incivek® (telaprevir) or Victrelis® (boceprevir).
Questions: If you have questions, call the Clinical Pharmacy Services Call Center for Nevada Medicaid at 855-455-3311.

DATE OF REQUEST:		
RECIPIENT INFORMATION		
Last Name, First Name, Middle Initial:		Date of Birth:
Recipient ID:	Gender: ☐ Male ☐ Female	Phone:
PRESCRIBING PROVIDER INFORMATION		
Name:	NPI:	Specialty:
Phone:	Fax (required):	
Person to contact regarding this request:		
DIAGNOSIS AND REQUESTED DRUG		
Name:	Strength:	
Dosage:	Duration:	

Please document the recipient's prior treatment status:

☐ Treatment naïve
☐ Null responder to previous treatment
☐ Partial responder to previous treatment
☐ Relapser to previous treatment

CLINICAL INFORMATION

Check the applicable boxes to indicate each item as true for the recipient:

☐ This request is for continuing therapy (leave blank for initial therapy).
☐ The recipient has a diagnosis of chronic hepatitis C genotype 1 infection.
☐ The recipient will be treated concomitantly with pegylated interferon alfa and ribavirin for the duration of therapy (plus 4-week lead-in if requesting Victrelis®).

Requests for Incivek® (initial request will be approved for 8 weeks, through treatment week 8)

☐ The recipient has not received a previous course of therapy with Incivek® (telaprevir) or Victrelis® (boceprevir).
☐ The recipient will be switching therapy from Victrelis® (boceprevir) to Incivek® (telaprevir) due to an adverse event.

If requesting additional 4 weeks of therapy (through week 12):

☐ The recipient's HCV-RNA level is <1000 IU/mL at treatment week 4.

Requests for Victrelis® (initial requests will be approved for 24 weeks, through treatment week 28)

☐ The recipient has not received a previous course of therapy with Incivek® (telaprevir) or Victrelis® (boceprevir).
☐ The recipient will be switching therapy from Incivek® (telaprevir) to Victrelis® (boceprevir) due to an adverse event.
☐ The recipient has an allergy, history of unacceptable/toxic side effects, drug-drug interaction or therapeutic failure with Incivek®. *Please document:*_____
☐ Victrelis® is being requested for a unique indication that is supported by peer-reviewed literature or a unique FDA-approved indication. *Please document:*_____

If requesting additional 8 weeks of therapy (through treatment week 36):

☐ The recipient is treatment-naïve and their HCV-RNA level was detectable at treatment week 8 and undetectable at treatment week 24.
☐ The recipient is a previous partial responder or a relapser to interferon and ribavirin and their HCV-RNA was undetectable at treatment week 8 and treatment week 24.

If requesting additional 20 weeks of therapy (through treatment week 48):

☐ The recipient has compensated cirrhosis and their HCV-RNA was undetectable at treatment week 24.
☐ The recipient had a <2-$\log_{10}$ HCV-RNA drop by treatment week 12 on prior treatment with pegylated interferon alfa and ribavirin and HCV-RNA on triple therapy is undetectable at treatment week 24.
☐ The recipient is treatment-naïve and poorly interferon responsive based on <1-$\log_{10}$ decline in HCV-RNA at treatment week 4 with pegylated interferon alfa and ribavirin and HCV-RNA is undetectable at treatment week 24.

Quantity limits: Incivek®:168 tablets per 25 days Victrelis®: 336 tablets per 25 days

PROVIDER CERTIFICATION – *Prescriber's signature and date required.*

I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Nevada Medicaid.

Prescriber's Signature: _____ **Date:** _____

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.