HEPATITIS C AGENTS PRIOR AUTHORIZATION FORM

(form effective 1/5/2026)

Community HealthChoices | AmeriHealth Caritas Pennsylvania | PERFORMRX℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-855-851-4058**, or to speak to a representative call **1-888-674-8720**.

PRIOR AUTHORIZATION REQUEST INFORMATION

Office contact name/phone:	
LTC facility contact/phone:	Total # pages:

BENEFICIARY INFORMATION

Beneficiary name:	Beneficiary ID #:	DOB:

PRESCRIBER INFORMATION

Prescriber name:		
Specialty:	NPI:	State license #:
Street address:		
City/state/zip:		
Phone:	Fax:	

CLINICAL INFORMATION

Requested drug #1:	
Directions:	
Qty:	☐ 8 weeks ☐ 12 weeks ☐ 16 weeks ☐ Other:
Requested drug #2:	
Directions:	
Qty:	☐ 8 weeks ☐ 12 weeks ☐ 16 weeks ☐ Other:

Is the beneficiary currently being treated with the requested drug(s)? ☐ Yes – Therapy start date: _____ ☐ No

SUBMIT DOCUMENTATION from the medical record for all items below.

For requests for NON-PREFERRED Hepatitis C Agents direct-acting antivirals (DAAs):

1. **Documentation that the beneficiary tried and failed or has a contraindication or intolerance to the preferred Hepatitis C Agents. (See the Preferred Drug List for the list of preferred Hepatitis C Agents at: https://papdl.com/preferred-drug-list.)**

   List medications tried:_____

2. **Cirrhosis assessment documented by a recent noninvasive test and date of testing.**
3. **Genotype if one of the following (check the appropriate box for the beneficiary):**
   - ☐ The beneficiary is prescribed a non-pangenotypic regimen.
   - ☐ The beneficiary is hepatitis C sofosbuvir-based, sofosbuvir-velpatasvir-voxilaprevir, or sofosbuvir plus glecaprevir-pibrentasvir treatment-experienced.
   - ☐ The beneficiary has decompensated cirrhosis and is prescribed ledipasvir-sofosbuvir.
   - ☐ The beneficiary is treatment-naïve (with cirrhosis) and prescribed sofosbuvir-velpatasvir.
4. **RAS (resistance-associated substitutions) testing and date of testing if one of the following (check the appropriate box for the beneficiary):**
   - ☐ The beneficiary is genotype 1a and prescribed elbasvir-grazoprevir.
   - ☐ The beneficiary is genotype 1a, treatment-experienced, and prescribed ledipasvir-sofosbuvir.
   - ☐ The beneficiary is genotype 3, treatment-naïve (with cirrhosis) or treatment-experienced (without cirrhosis) and prescribed 12 weeks of sofosbuvir-velpatasvir.

For requests for THERAPEUTIC DUPLICATION of Hepatitis C Agents direct-acting antivirals (DAAs):
For a beneficiary taking more than 1 Hepatitis C Agents DAA product concomitantly:
- ☐ The beneficiary has a medical reason for concomitant use of the requested products that is supported by peer-reviewed medical literature or national treatment guidelines.

For requests for ALL OTHER NON-PREFERRED Hepatitis C Agents (e.g., Pegasys): Diagnosis: _____
- ☐ The beneficiary has a history of therapeutic failure of or a contraindication or an intolerance to first line therapies.

List therapies tried:_____

ATTESTATION from the prescriber for one of the items below.

Check the appropriate box for the beneficiary.
- ☐ The beneficiary is hepatitis C treatment naïve.
- ☐ The beneficiary has been treated for hepatitis C with the following treatment regimen: _____

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: