Aetna Better Health® of Louisiana Pharmacy Prior Authorization Request Form
Direct-Acting Antiviral (DAA) Agents Used to Treat Chronic Hepatitis C Virus (HCV)
Fax back to 1-844-699-2889

Note: This worksheet must be completed in full and submitted with supporting documentation where applicable. [See DAA Clinical Authorization Criteria]

Recipient Name:	Medicaid Recipient ID #:		Recipient DOB:	Recipient weight:
Prescriber Name:	Prescriber Specialty:	Medicaid Provider ID #:	Office Contact:	

Medication regimen requested *[Choose one.]*

☐ Daclatasvir (Daklinza™)	☐ Daclatasvir / Sofosbuvir (Daklinza™/ Sovaldi®)
☐ Elbasvir / Grazoprevir (Zepatier®)	☐ Glecaprevir / Pibrentasvir (Mavyret™)
☐ Ledipasvir / Sofosbuvir (Harvoni®)	☐ Ombitasvir / Paritaprevir / Ritonavir with Dasabuvir (Viekira Pak™)
☐ Ledipasvir / Sofosbuvir (Authorized Generic (AG) of Harvoni®)	☐ Sofosbuvir / Velpatasvir (Epclusa®)
☐ Sofosbuvir (Sovaldi®)	☐ Sofosbuvir / Velpatasvir / Voxilaprevir (Vosevi™)

☐ Sofosbuvir / Velpatasvir (Authorized Generic (AG) of Epclusa®)
[This form is not necessary because Epclusa® AG is preferred and does not require authorization.]

Duration of therapy requested: ____weeks
[If duration is greater than minimum duration stated per prescribing information, please provide rationale below for extended duration.]

Reason for extended duration request (if applicable):

Does patient have a diagnosis of Chronic Hepatitis C (HCV)? ☐ Yes ☐ No Please specify genotype:

Is patient treatment-naïve? ☐ Yes ☐ No If no, provide previous HCV therapy:

Was previous therapy completed? ☐ Yes ☐ No If no, provide reason for discontinuation.

Has the patient experienced treatment failure with the preferred product? ☐ Yes ☐ No

Has the patient had an intolerable side effect with the preferred product? ☐ Yes ☐ No
If yes, please explain in detail:

Does the patient have documented contraindication(s) to the preferred product? ☐ Yes ☐ No
If yes, please explain in detail:

If there is no preferred product that is appropriate to use for the condition being treated, please explain in detail:

By signing below, the prescriber attests that the information provided herein is true and accurate to the best of his/her knowledge. Also, by signing and submitting this request form, the prescriber attests to statements in the 'Attestation' section of the criteria specific to this request.

Physician Signature:* _____ **Date:**_____

***** *(Signature stamps and proxy signatures are not acceptable.)*

Direct-Acting Antiviral (DAA) Agents Used to Treat Chronic Hepatitis C Virus (HCV)
Treatment Agreement for Louisiana Medicaid Recipients

Prescriber Instructions: Please submit the completed treatment agreement with the initial clinical authorization request for the **non-preferred** Direct-Acting Antiviral Agent(s) (DAA) for Hepatitis C.

Patient Information	**Prescriber Information**	
Recipient Name:	Prescriber Name:	
Medicaid Recipient ID #:	Medicaid Provider ID # or NPI:	
Date of Birth:	Office Contact:	
Hepatitis C Medication Regimen:	Provider Phone Number:	Provider Fax Number:

Patient Instructions: Please read this treatment agreement carefully. Please initial each item to show you have read and understand it. Be sure to ask any questions you have before you sign it. Sign and date at the bottom of the form.		**Patient's Initials**
1.	I have been told how to take my hepatitis C medicines. I understand how to take them. I am aware of possible side effects. I understand why it is important to finish all the therapy.	
2.	I will take my hepatitis C medicines like my doctor said. I will not miss doses.	
3.	I will tell my doctor and pharmacist the medicines I take. I understand there may be some medicines I cannot take with my hepatitis C medicines.	
4.	If I am taking ribavirin, I am (OR my female partner is) not pregnant.	
5.	If I am taking ribavirin, I am (OR my female partner is) not planning on getting pregnant while I am on my hepatitis C medicines and for at least 6 months after I finish them.	
6.	If I am taking ribavirin, I (OR my female partner) will use two forms of effective contraception while I am taking my hepatitis C medicines and for at least 6 months after I finish them.	
7.	If I am taking ribavirin, I (OR my female partner) will have monthly pregnancy testing while I am taking my hepatitis C medicines.	

I have read the above statements and understand the agreement.

Patient Signature:_____ **Date:**_____

Physician Signature:_____ **Date:**_____