Prescription Medication Prior Authorization Request Form

☐ Standard PA Request ☐ Urgent/Expedited PA Request

Please fill out all sections and attach any important documentation such as chart notes or lab results to support the PA request.
Once completed submit to WithMe Health via fax at **1-866-678-8301**

Patient Information

Patient Name (Last, First, MI):		
Member ID Number:	Date of Birth:	Patient Phone Number:
Patient Address:		
Patient's Authorized Representative (If applicable):		Authorized Rep Phone Number:

Provider Information

Requesting Provider's Name:		
NPI:	Specialty:	
Office Address:		
Office Phone:	Office Fax:	
Office Contact Name:	Phone:	Fax:
Dispensing Pharmacy Name/Place of Service:	Phone:	Fax:

Requested Medication Information

Medication Name and Strength:	
Dose and Frequency (Sig):	
Qty Per 30 Days:	Expected Duration of Therapy:
ICD-10(s):	Diagnosis:

Please check one of the boxes below. If established, please include therapy start date:

☐ New Therapy ☐ Samples ☐ Clinical Trial ☐ Established Date Therapy Started: _____

Previous Therapies Used for Diagnosis (Rx and OTC products)

Medication Name, Strength, Dose, Frequency	Dates Used	Outcome of Therapy (e.g., Ineffective, Not Tolerated)

Medical Rationale for Use of Requested Medication (**Please attach chart notes, lab work etc. when submitting this request. If applicable, please include why formulary therapies may be contraindicated for this patient.** Please also include which therapies will be used along with the requested medication. If patient is established on the requested medication, please include recent documentation of how the patient has responded to therapy.):

Disease State Specific Questions

If patient requires treatment with Epclusa (sofosbuvir/velpatasvir), please provide the following information:

1. Does the patient have a diagnosis of chronic genotype 1, 2, 3, 4, 5, or 6 HCV infection? ☐ Yes ☐ No
2. Does the patient also have decompensated cirrhosis? ☐ Yes ☐ No
3. Will the drug be used in combination with Ribavirin? ☐ Yes ☐ No
4. Please provide the baseline documentation for the following:
   - ☐ Transplant status
   - ☐ Child-Pugh Score/ cirrhosis level

If patient requires treatment with Harvoni (ledipasvir/sofosbuvir), please provide the following information:

1. Does the patient have a diagnosis of chronic genotype 1, 2, 3, 4, 5, or 6 HCV infection? ☐ Yes ☐ No
2. Does the patient also have decompensated cirrhosis (Child-Pugh B/C)? ☐ Yes ☐ No
3. Is the patient post liver transplant? ☐ Yes ☐ No
4. Does the patient have HCV genotype 1 treatment-experienced patients with compensated cirrhosis (Child-Pugh A)? ☐ Yes ☐ No
5. Will the drug be used in combination with Ribavirin? ☐ Yes ☐ No
6. Please provide the baseline documentation for the following:
   - ☐ Transplant status
   - ☐ Child-Pugh Score/ cirrhosis level
   - ☐ Documentation of pre-treatment HCV RNA is provided that is at least greater than 25 IU/mL.

If patient requires treatment with Mavyret (glecaprevir/pibrentasvir), please provide the following information:

1. Does the patient have a diagnosis of chronic genotype 1, 2, 3, 4, 5, or 6 HCV infection? ☐ Yes ☐ No
2. Please indicate which of the following apply to the patient**:**
   - ☐ The member is treatment-naïve
   - ☐ The member has failed an HCV regimen containing interferon, pegylated interferon, ribavirin, and/or sofosbuvir
   - ☐ The member has a diagnosis of HCV genotype 1
   - ☐ The member has previously been treated with a regimen containing an HCV NS5A inhibitor or an NS3/4A protease inhibitor but not both
3. Please provide the baseline documentation for the following:
   - ☐ Transplant status
   - ☐ Child-Pugh Score/ cirrhosis level

If patient requires treatment with : **Viekira Pak (ombitasvir/ paritaprevir/ ritonavir/ dasabuvir), please provide the following information:**

1. Does the patient have a diagnosis of chronic genotype 1a HCV infection? ☐ Yes ☐ No
2. Will the drug be used in combination with Ribavirin? ☐ Yes ☐ No
3. Please provide the baseline documentation for the following:
   - ☐ Transplant status
   - ☐ Child-Pugh Score/ cirrhosis level

If patient requires treatment with : **Vosevi (sofosbuvir/velpatasvir/voxilaprevir), please provide the following information:**

1. Does the patient have a diagnosis of chronic genotype 1, 2, 3, 4, 5, or 6 HCV infection? ☐ Yes ☐ No
2. Has the patient previously been treated with an HCV regimen containing an NS5A inhibitor (e.g. Harvoni, Mavyret, Epclusa, etc)? ☐ Yes ☐ No
3. Does the patient have a diagnosis of HCV genotype 1a or 3 and has previously been treated with an HCV regimen containing sofosbuvir without an NS5A inhibitor (e.g. Harvoni, Mavyret, Epclusa, etc.)? ☐ Yes ☐ No
4. Please provide the baseline documentation for the following:
   - ☐ Transplant status
   - ☐ Child-Pugh Score/ cirrhosis level

If patient requires treatment with: **Zepatier (elbasvir/grazoprevir**), **please provide the following information:**

1. Does the patient have diagnosis of chronic genotype 1 or 4 HCV infection? ☐ Yes ☐ No
2. Does the patient fall into any of the following treatment groups? If so, please indicate which one.
   - ☐ Genotype 1a with baseline NS5A polymorphisms.
   - ☐ Genotype 1 peginterferon/ribavirin or NS3/4A protease inhibitor experienced. (See Appendix 3)
   - ☐ Genotype 4 peginterferon/ribavirin experienced.
   - ☐ None of the above
3. Will the drug be used in combination with Ribavirin? ☐ Yes ☐ No
4. Please provide the baseline documentation for the following:
   - ☐ Transplant status
   - ☐ Child-Pugh Score/ cirrhosis level

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by WithMe Health, the health plan sponsor, or, if applicable, a state or federal regulatory agency.

_____ _____

Provider Signature Date