BlueCross BlueShield Nebraska

HEPATITIS C THERAPY
POLICY X.31
PREAUTHORIZATION REQUEST
PRESCRIBER FAX FORM

Only the prescriber may complete this form for prospective reviews.
The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit NebraskaBlue.com. *Start saving time by filling out this preauthorization form electronically at* MedicalPolicy.NebraskaBlue.com.

What is the priority level of this request?

☐ Standard review - Completed within 15 calendar days of receipt.

☐ Expedited/Urgent review - If the standard time period for a decision could seriously jeopardize the life or health of patient could not be adequately managed; completed within 72 hours of receipt.

Today's Date: _____

Patient and Insurance Information

Patient First Name:	Patient Last Name:	Middle Initial:	Date of Birth (mm/dd/yyyy):
Patient Address:	City, State, ZIP	Member ID Number:	

Prescriber Information

Prescriber Name:	Prescriber NPI:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, ZIP:	Clinic Phone Number:	Secure Fax Number:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Medication Requested: ☐Harvoni ☐Epclusa ☐Mavyret ☐Vosevi ☐Daklinza ☐Ledipasvir/sofosbuvir 90/400mg-AG of Harvoni
☐Zepatier ☐Sovaldi ☐Olysio ☐Pegasys ☐Viekira ☐Sofosbuvir/velpatasvir 400/100mg-AG of Epclusa

Dose/Treatment duration requested _____ | Diagnosis for use: _____

Genotype: _____ | Baseline HCV RNA: _____ IU/mL

1. Is the patient treatment naive?..... ☐Yes ☐No

If no, please list previous treatment(s) and outcome(s):

Treatment #1: _____ Outcome: _____
Treatment #2: _____ Outcome: _____
Treatment #3: _____ Outcome: _____

2. Does the patient have evidence consistent with cirrhosis?..... ☐Yes ☐No

If yes: ☐Compensated OR ☐Decompensated

Preferred start date: _____

3. Was a urine drug screen submitted?..... ☐Yes ☐No

4. Were labs, notes and tests submitted indicating level of fibrosis and/or cirrhosis?..... ☐Yes ☐No

Please fax or mail this form to:
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Pharmacy Department - UM
PO Box 3248
Omaha, NE 68180-0001

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