04/28/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Incivek (IL88)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois Medicaid at **1-855-684-5250**.
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Incivek (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Incivek (telaprevir)

Quantity __________ Frequency _______________ Strength ___________

Route of Administration __________ Expected Length of therapy ______________

Patient Information

Patient Name: ________________________________
Patient ID: ________________________________
Patient Group No.: ________________________________
Patient DOB: ________________________________
Patient Phone: ________________________________

Prescribing Physician

Physician Name: ________________________
Physician Phone: ________________________
Physician Fax: ________________________
Physician Address: ________________________
City, State, Zip: ________________________

Diagnosis:_____________________________ **ICD Code:**_____________________________

Please circle the appropriate answer for each question.

1. Has Aetna Better Health authorized this medication in the past for this patient (i.e., previous authorization is on file under Aetna Better Health)? Y N

   [If yes, skip to question 5: REAUTHORIZATION REQUESTS]

2. INITIAL AUTHORIZATION REQUESTS: Does the patient meet all of the following? Please document prescriber specialty and patient treatment type (treatment naïve, previous relapser, partial responder, or null responder): Y N

   Patient is 18 years of age, or older \ Diagnosis is chronic

hepatitis C (HCV) genotype 1 infection \ Incivek will be used in combination with peg-interferon and ribavirin. Note: If peginterferon alfa or ribavirin is discontinued for any reason, Incivek must also be discontinued. \ Patient treatment type is documented (treatment naïve, previous relapser, partial responder, null responder). \ Therapy is prescribed by, or in consultation with a gastroenterologist, hepatologist or infectious diseases specialist.

[If no, no further questions.]

3. Does the patient have any of the following? If yes, please document: Y N

   HIV coinfection \ Hepatitis B coinfection \ Organ transplant recipient \ Decompensated liver disease \ Previous failure of HCV NS3/4A protease inhibitor-based treatment

   [If yes, no further questions.]

4. Will the patient's HCV-RNA level be assessed at treatment week 4, treatment week 12, and treatment week 24? Y N

   [No further questions.]

5. REAUTHORIZATION REQUESTS: Has the patient completed at least 4 weeks of therapy with Incivek? Please document actual treatment start date: Y N

   ____

   [If no, no further questions.]

6. Have the treatment week 4 HCV-RNA levels been drawn? Y N

   [If no, no further questions.]

7. Is the patient's treatment week 4 HCV-RNA level either undetectable or less than or equal to 1000 IU/ml? Please document HCV-RNA and date drawn: Y N

   ____

   [If no, no further questions.]

8. Has the patient completed 12 weeks of therapy with Incivek? Y N

Comments:

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I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature	**Date**