



An Independent Licensee
of the Blue Cross and
Blue Shield Association

Precertification Request Form for **Incivek®**

Precertification for Incivek® requires completion of this form in its entirety. All requested data must be provided. Once completed the form must be signed by the medical provider and faxed back to BCBSAZ Pharmacy Management at **(602) 864-3126**. Incomplete forms may result in denial of requested medication due to lack of needed information.

Provider Information				Patient Information			
Physician's Name				Patient's Name			
Physician Specialty		NPI #		BCBSAZ Member ID			
Mailing Address				Date of Birth / /		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
City	State	Zip Code		Patient's Address			
Phone # () - ext		Fax # () -		City	State	Zip Code	

Medication Information

Medication Name & Strength:	
Directions for Use & Duration:	
Diagnosis Code:	
Diagnosis:	

All of the following questions and/or information must be answered and provided to assess request:

Yes	No	
		Individual has a confirmed diagnosis of chronic Hepatitis C virus infection genotype 1
		Incivek will only be used with both pegylated interferon alfa and ribavirin
		HCV treatment duration will follow Response Guided Therapy recommendations
		HCV treatment will follow Treatment Futility recommendations to predict HCV treatment failure
		Maximum duration of Incivek therapy will be 12 weeks, in the absence of Treatment Futility
		Quantitative HCV RNA at end of treatment week 4 or 12 of >1000 IU/mL will result in stopping all HCV therapy
		A detectable quantitative HCV RNA at the end of treatment week 24 will result in stopping all HCV therapy

I have ruled out the following conditions and/or circumstances:

	Yes	No	
			Co-infection with either HIV or Hepatitis B or has a solid organ transplant
			Child-Pugh score ≥ 6 with or without cirrhosis
			Contraindications to Incivek, pegylated interferon alfa and ribavirin
			Previous course of or receiving a repeat course of either Incivek or Victrelis
			Pregnancy or likely to become pregnant or breast feeding

Provider must indicate individual type:

Treatment naïve Prior Relapse Prior Partial response Null response Compensated cirrhosis

Provider must supply Quantitative HCV RNA values (Baseline must always be given):

Baseline: _____ Follow-up: _____
Follow-up was obtained at end of treatment week: Week 4 Week 12 Week 24

For BCBSAZ use only: HCV treatment duration in absence of Treatment Futility:

	24 weeks for Treatment naïve or Prior Relapse individuals with undetectable HCV RNA at end of week 4 and 12 (Incivek for first 12 weeks, then pegylated interferon alfa and ribavirin for additional 12 weeks)
	48 weeks for all other individuals (Incivek for first 12 weeks, then pegylated interferon alfa and ribavirin for additional 36 weeks)

Signature affirms that information given on this form is true and accurate and reflects office notes

Physician's Signature	Date
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