



BlueCross
BlueShield
of Arizona

An Independent Licensee
of the Blue Cross and
Blue Shield Association

Precertification Request Form for
Victrelis®

Precertification for Victrelis® 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 and Patient Information sections with fields for Physician's Name, Specialty, NPI, Mailing Address, City, State, Zip Code, Phone/Fax numbers, Patient's Name, BCBSAZ Member ID, Date of Birth, Gender, and Patient's Address.

Medication Information section with fields for Medication Name & Strength, Directions for Use & Duration, Diagnosis Code, and Diagnosis.

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

Table with Yes/No columns and questions regarding HCV diagnosis, treatment duration, and RNA levels.

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

Table with Yes/No columns and conditions to be ruled out, such as co-infection with HIV or Hepatitis B, Child-Pugh score, and pregnancy.

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: done @: Week 4, Week 8, Week 12, Week 24

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

Table detailing HCV treatment duration options for 24, 32, and 44 weeks Victrelis, including criteria for treatment naïve, partial response, and compensated cirrhosis.

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

Signature and Date fields for the physician.