Cigna HealthSpring

Mail Requests To: Coverage Determination & Exceptions
PO BOX 20002, Nashville, TN 37202

Fax Requests To: (866) 845-7267
Request By Phone: (877) 813-5595

Hepatitis C Coverage Determination

(FOR PROVIDER USE ONLY)

MEMBER INFORMATION REQUIRED (Please Write Legibly)	
Customer Name:	**Customer ID:**
Customer DOB:	**Customer Address:**
Phone (Home):	**Phone (Cell):**

PROVIDER INFORMATION REQUIRED (Please Write Legibly)		
License Number:	**DEA Number:**	**NPI Number:**
Provider Name:	**Provider Address:**	
Provider Phone:	**Provider Fax:**	
Provider Specialty:	**Office Contact Name:**	

DRUG & PRESCRIPTION INFORMATION REQUIRED (Please Write Legibly)

Drug Name: _____ **Dosage:** _____

Frequency: _____ **Quantity:** _____ **Refills:** _____

☐ ***Do Not Substitute-Dispense As Written***

Please check whether this is a new medication or therapy continuation

☐ **New Medication** ☐ **Continuation**

If you have checked "Continuation",
Provide Start Date---------> _____

SELECT DIAGNOSIS

- ☐ **Hepatitis C- Naïve**
- ☐ **Hepatitis C-Relapsed or Previous Failure**
- ☐ **Hepatitis B (Chronic)**
- ☐ **Condylomate Acuminata**
- ☐ **Follicular Lymphoma**
- ☐ **Hairy Cell Leukemia**
- ☐ **Malignant Melanoma**
- ☐ **AIDS related KS**

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Other Questions:

List Genotype: _____

List weight in Kg: _____

Please provide member's HCV-RNA levels: _____

Does the customer have cirrhosis? ☐ YES ☐ NO

Is the Cirrhosis: ☐ Compensated ☐ Decompensated

Has the patient received liver transplant? ☐ YES ☐ NO

Is this request for an inpatient that is awaiting discharge? ☐ YES ☐ NO

Continuation:

Has a positive virologic response been demonstrated with a negative HCV RNA? ☐ YES ☐ NO

Has a positive virologic response been demonstrated with a log decrease in HCV RNA from baseline? ☐ YES ☐ NO

Re-Treatment:

List the drug dose, frequency and duration of therapy of the patient's previous therapy trials/failures:

_____

_____

If the customer is unable to meet the criteria required for the requested medication, please provide a clinical explanation as to why an exception should be made:

_____

_____

Administration Site: ☐ Patient's home ☐ Home infusion ☐ Skilled nursing
☐ Physician's office ☐ Long Term Care ☐ Other: _____

Drug Supplied By: ☐ Pharmacy ☐ Physician's Supply ☐ Other: _____

Additional information must be submitted to support medical necessity

☐ ***Request for expedited review [24 hours]. By checking this box, I certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the Customer or the Customer's ability to regain maximum function***

Provider Signature: **Date:**