Hepatitis C Treatments Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-512-9004.
Provider Help Desk: 800-454-3730

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____

7. Diagnosis:

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization (PA) is required for hepatitis C treatments. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agents would be medically contraindicated. Payment will be considered under the following conditions:

1) Patient has a diagnosis of chronic hepatitis C; and
2) Patient's age and/or weight is within the FDA labeled age and/or weight; and
3) Patient has had testing for hepatitis C virus (HCV) genotype; and
4) Patient has an active HCV infection verified by a detectable viral load within 12 months of starting treatment; and
5) Patient has been tested for hepatitis B (HBV) prior to initiating treatment of HCV and individuals with active HBV infection are treated (either at same time as HCV therapy or before HCV therapy is started); and
6) Patient's prior treatment history is provided (treatment naïve or treatment experienced); and
7) If patient has a history of non-compliance, documentation that steps have been taken to correct or address the causes of non-compliance are provided; and
8) Patient has abstained from the use of illicit drugs and alcohol for a minimum of three months as evidenced by a negative urine confirmation test; and
9) HCV treatment is prescribed by or in consultation with a digestive disease, liver disease, or infectious disease provider practice; and
10) For patients on a regimen containing ribavirin, documentation of the following on the PA form:

a) Patient is not a pregnant female or a male with a pregnant female partner; and
b) Women of childbearing potential and their male partners must use two forms of effective contraception during treatment and for at least 6 months after treatment has concluded; and
c) Monthly pregnancy tests will be performed during treatment; and

11) Prescriber has reviewed the patient's current medication list and acknowledged that there are no significant drug interactions with the HCV medication.
12) Documentation is provided for patients who are ineligible to receive ribavirin.
13) Non-FDA approved or non-compendia indicated combination therapy regimens will not be approved.
14) Patient does not have limited life expectancy (less than 12 months) due to non-liver-related comorbid conditions.
15) If patient is recently eligible for Iowa Medicaid, and has been started and stabilized on therapy while covered under a different plan, documentation of how long the patient has been on medication will be required. Patient will be eligible for the remainder of therapy needed, based on established length of therapy for the particular treatment (defined below).
16) Lost or stolen medication replacement requests will not be authorized.
17) The 72-hour emergency supply rule does not apply to hepatitis C treatments.
18) Only one treatment attempt will be allowed per calendar year, regardless of compliance.

Preferred

☐ Mavyret
☐ Sofosbuvir/Velpatasvir
☐ Harvoni 45 to 200 mg (3 to 11 years old and < 35 kg)
☐ Sovaldi 200 mg (3 to 11 years old and < 35 kg)

Nonpreferred

☐ Epclusa
☐ Harvoni
☐ Ledipasvir/Sofosbuvir
☐ Zepatier
☐ Vosevi

Instructions for completing the *Hepatitis C Treatments PAB Form*:
Section 1 of the PA form lists the various regimens and clinical situations for which hepatitis C treatments will be considered medically necessary according to Iowa Medicaid PA criteria. Section 2 includes additional supporting documentation that is required on the PA form.

- Check **one** box in Section 1 — Treatment Regimen.
- Review and complete each numbered item in Section 2 — Supporting Documentation.
- Attach lab results, chart notes, and other documentation, sign and fax the completed form to **800-574-2515**.

Section 1 — Treatment Regimen

Check **one** box below to indicate the requested treatment regimen based on the patient's genotype, treatment history, and extent of liver disease.

Treatment naive
No cirrhosis
☐ Mavyret 100/40 mg, three (3) tablets daily for 8 weeks (for GT5/6 and/or HIV/HCV co-infection, 12 weeks is recommended)
☐ Sofosbuvir/Velpatasvir 400/100 mg, one tablet daily for 12 weeks
Compensated cirrhosis, HIV negative
☐ Mavyret 100/40 mg, three (3) tablets daily for 8 weeks
☐ Sofosbuvir/Velpatasvir 400/100, one tablet daily for 12 weeks (for GT3, add weight based ribavirin (RBV) if Y93H positive)
Compensated cirrhosis, HIV positive

☐ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks
☐ Sofosbuvir/Velpatasvir 400/100 mg, one tablet daily for 12 weeks (for GT3, add weight based RBV if Y93H positive)
Treatment experienced
Sofosbuvir-based regimen
☐ Mavyret 100/40 mg, three (3) tablets daily for 16 weeks
NS3/4 protease inhibitor inclusive regimen (e.g., Zepatier)
☐ Vosevi 400/100/100 mg, one tablet daily for 12 weeks
Mavyret
☐ Vosevi 400/100/100 mg, one tablet daily for 12 weeks (if compensated cirrhosis, add weight-based RBV)
Vosevi or sofosbuvir + Mavyret
☐ Vosevi 400/100/100 mg, one tablet daily and weight-based RBV for 24 weeks
GT 3 only: sofosbuvir/NS5A (e.g. Harvoni)
☐ Vosevi 400/100/100 mg, one tablet daily and weight-based RBV for 12 weeks
Re-infection of Allograft Liver after transplant
Direct acting antiviral (DAA)-treatment naïve, no decompensated cirrhosis
☐ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks
☐ Sofosbuvir/Velpatasvir 400/100 mg, one tablet daily for 12 weeks
DAA-treatment experienced, no decompensated cirrhosis
☐ Vosevi 400/100/100 mg, one tablet daily for 12 weeks
IF multiple negative baseline characteristics, consider
☐ Vosevi 400/100/100 mg, one tablet daily and low dose[1] RBV for 12 weeks
Treatment naïve, decompensated cirrhosis
☐ Sofosbuvir/Velpatasvir 400/100 mg, one tablet daily and low dose[1] RBV for 12 weeks
Treatment experienced, decompensated cirrhosis (Child-Pugh B or C ONLY)
☐ Sofosbuvir/Velpatasvir 400/100 mg, one tablet daily and low dose[1] RBV for 24 weeks
Decompensated Cirrhosis
No prior sofosbuvir or NS5A failure
☐ Sofosbuvir/Velpatasvir 400/100 mg and weight-based RBV daily for 12 weeks (low dose[1] RBV recommended for Child-Pugh class C cirrhosis) ☐ Sofosbuvir/Velpatasvir 400/100 mg daily for 24 weeks (will be approved only for patients with documented ineligibility for RBV)
Prior sofosbuvir or NS5A failure
☐ Sofosbuvir/Velpatasvir 400/100 mg and weight-based RBV daily for 24 weeks (low dose* RBV if Child-Pugh C)
Other treatment regimen Genotype, treatment history and extent of liver disease: _____ _____ Drug name, dose and duration: _____ _____ _____ _____

Clinical rationale for selecting regimens other than those outlined above: _____

1 Low dose ribavirin: 600 mg/day and increase as tolerated

Section 2 — Supporting Documentation

Review and complete each numbered item below to provide the supporting documentation for the PA request.

Diagnosis:

1. Pretreatment viral load (attach results): _____
   Date obtained: _____

Patient history:

2. Does the patient have a history of noncompliance? Yes ☐ No ☐
   If yes, submit chart notes documenting the steps taken to correct or address the non-compliance (**attach chart notes**).
3. Documentation in provider notes (**must be submitted**) showing that member has had no abuse of alcohol and drugs for the previous 3 months. **MUST submit** urine drug screen for members with history of abuse of drugs other than alcohol. Counseling MUST be provided and documented regarding non-abuse of alcohol and drugs as well as education on how to prevent HCV transmission.
4. Has patient been screened for Hepatitis B? ☐ No Yes; Date: _____
   Active disease: ☐ No ☐ Yes, if yes, has patient been treated or currently being treated? ☐ No ☐ Yes
5. Patient weight: _____ Date obtained: _____
6. Does patient have a limited life expectancy (less than 12 months) due to non-liver-related comorbid conditions? Yes ☐ No ☐

Prescriber information:

7. Provider practice: ☐ Digestive disease ☐ Liver disease ☐ Infectious disease
   ☐ Other: _____
   If other, note consultation with specialist:
   Consultation date: _____
   Physician name, phone and specialty: _____

Regimens containing Ribavirin:

8. If the patient is female and of childbearing potential, or the patient is male with a female partner of childbearing potential, the prescriber must acknowledge the following:
   ☐ The patient is not pregnant (or a male patient with a pregnant female partner) and is not planning to become pregnant during treatment or within 6 months of stopping treatment.
   ☐ Both partners will use two forms of effective contraception during treatment and for at least 6 months after stopping treatment.
   ☐ Monthly pregnancy tests will be performed throughout treatment.

9. Complete blood count with differential (**attach results**)
10. If the patient is ineligible for ribavirin, select the appropriate reason from the list below:
    - ☐ History of severe or unstable cardiac disease
    - ☐ Pregnant women and men with pregnant partners
    - ☐ Diagnosis of hemoglobinopathy (e.g., thalassemia major, sickle cell anemia)
    - ☐ Hypersensitivity to ribavirin
    - ☐ Baseline platelets <70,000 cells/µL
    - ☐ Baseline absolute neutrophil count <1,500 cells/µL
    - ☐ Baseline hemoglobin <12 g/dL in women or <13 g/dL in men
    - ☐ Other: _____

      _____

Note: Laboratory values will be reviewed and requests will not be considered if labs are outside of a specific range. Patients with CrCl < 50 ml/min (moderate or severe renal dysfunction, ESRD, HD) should have dosage reduced.

Potentially significant drug interactions

By checking the following box, the prescriber attests that they have reviewed the patient's medications for potentially significant drug interactions with the Hepatitis C treatment on an electronic drug interaction website.

☐ Website used: _____ Date completed: _____

Attach lab results and other documentation.

9. Physician signature

_____

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Important note: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint ofmedical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*