Print Reset

Alaska Medicaid

Hepatitis C Direct-Acting Antivirals – New Start Prior Authorization Form

This form may also be used for requests to exceed the maximum allowed units.
Form available on Alaska Medicaid's Medication Prior Authorization website

Fax this form to (888) 603-7696

This authorization request does not ensure eligibility and is not a guarantee of payment. Please verify Medicaid eligibility before completing this form. Incomplete requests will be denied until all required information is received.

Request Date: _____

REQUESTOR INFORMATION

Requestor Name: _____ Title: _____

MEMBER INFORMATION

Last Name: _____ First Name: _____

Member ID #: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female Member Phone: _____

PRESCRIBER INFORMATION

Last Name: _____ First Name: _____

Prescriber NPI: _____ Specialty: _____

Prescriber Phone: _____ Prescriber Fax: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

DRUG INFORMATION

Drug Name: _____ NDC: _____

Drug Strength: _____ Dosage Form: _____

Dosage Schedule: _____ Quantity: _____ Day Supply: _____

Last Name: _____ First Name: _____

INSTRUCTIONS TO THE PROVIDER

Please note the following criteria for approval and for denial of Hepatitis C Direct-Acting Antivirals (DAA) Clinical Criteria:

Additional Information:

- All questions must be answered, or the prior authorization (PA) request will be considered incomplete.
- If incomplete information is submitted, prescribers will have 7 calendar days to respond to the request for additional information, or the request will be non-clinically denied due to lack of information. A re-review is possible with the submittal of a new complete PA request.
- Claims will not be approved for more than a 28-day supply at a time.
- HCV RNA results from 12 weeks post-treatment (SVR 12) are required to be maintained in the medical record, to be made available at the State of Alaska's request.
- Lost or stolen medications will not be replaced.
- Neither extended authorization nor re-authorization of treatment will be granted in situations of treatment failure where the pharmacy provider made an error in dispensing the medication; in such cases, the pharmacy provider shall be responsible for rectifying the error at no cost to Alaska Medicaid or the patient.
- Certain medication regimens will require testing for the presence of resistance-associated viral polymorphisms.
- Prescribers are advised to review FDA-approved labeling and other available clinical resources when determining appropriate regimens based on contraindications and warnings, including clinically relevant drug-drug and drug-disease interactions, pregnancy status, as well as considerations for HIV/HCV and HBV/HCV co-infected individuals to ensure appropriate monitoring schema are taken into consideration.
- Approval will be based on preferred drug selection.
- Prescribers must assess patient readiness and a signed patient attestation must be included in the prior authorization request.

Alaska Medicaid Hepatitis C Direct-Acting Antivirals Prior Authorization Form

Last Name: _____ First Name: _____

CLINICAL INFORMATION

1. What is the diagnosis for which this drug is being requested? (Please attach documentation.)
   - ☐ Chronic Hepatitis C, genotype 1a
   - ☐ Chronic Hepatitis C, genotype 1b
   - ☐ Chronic Hepatitis C, genotype 2
   - ☐ Chronic Hepatitis C, genotype 3
   - ☐ Chronic Hepatitis C, genotype 4
   - ☐ Chronic Hepatitis C, genotype 5
   - ☐ Chronic Hepatitis C, genotype 6
   - ☐ Chronic Hepatitis C, mixed genotype: _____ _____ _____
   - ☐ Hepatocellular Carcinoma awaiting liver transplant
2. Is the requesting prescriber an Alaska Medicaid provider?
   ☐ Yes ☐ No
3. Has the patient had prior treatment for Chronic Hepatitis C?
   ☐ Yes ☐ No
   a. If **yes**, please list regimen(s) and dates below:

   Prior Hepatitis C Regimen(s):

   Regimen 1: _____ Regimen 2: _____

   Inclusive Dates:

   Regimen 1: _____ Regimen 2: _____

   Was prior regimen completed?

   Regimen 1: ☐ Yes ☐ No Regimen 2: ☐ Yes ☐ No

   If discontinued early, state the reason:

   Regimen 1: _____ Regimen 2: _____
4. METAVIR Fibrosis Score, equivalent *(attach documentation):*
   ☐ Unknown ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4
5. Does the patient have extrahepatic manifestations of Chronic Hepatitis C, the etiology of which can only be attributable to the HCV infection?
   (If yes, specify which manifestations and submit documentation.)
   ☐ Yes ☐ No

Alaska Medicaid Hepatitis C Direct-Acting Antivirals Prior Authorization Form

Last Name: _____ First Name: _____

6. Baseline HCV Viral Load: _____ IU/mL Date: _____

7. Child-Pugh score:

   Points: _____ ☐ A ☐ B ☐ C

8. Current (within past 90 days) renal function (creatinine clearance or GFR, estimated):

   _____ IU/mL

9. Is patient HIV co-infected?

   ☐ Yes ☐ No

10. Has patient been screened for HBV (HbsAg and anti-HBc)?

    ☐ Yes ☐ No

    If **yes**, HBV status: ☐ Positive *(refer to specialist)* ☐ Negative

11. If patient is female, has patient been screened and counseled on pregnancy?

    ☐ Yes/not pregnant ☐ No

12. Is a current list of all of the patient's medications attached? (Attach documentation. The list should include all scheduled maintenance and as-needed [PRN] medications the patient will be taking while on HCV therapy.)

    ☐ Yes ☐ No

13. Select **prescriber's specialty**:

    ☐ Gastroenterologist ☐ Internal Med

    ☐ Hepatologist ☐ Family Med

    ☐ Infectious Disease Specialist ☐ Other: _____

14. Select **consultant's specialty** (if applicable):

    ☐ Gastroenterologist ☐ Other: _____

    ☐ Hepatologist ☐ No other prescriber was consulted

    ☐ Infectious Disease Specialist

Alaska Medicaid Hepatitis C Direct-Acting Antivirals Prior Authorization Form

Last Name: _____ First Name: _____

REQUESTED REGIMEN

1. Select **requested regimen**:
   - ☐ Mavyret®
   - ☐ Sofosbuvir/Velpatasvir 400 mg–100 mg tablet
   - ☐ Ledipasvir/Sofosbuvir 90 mg–400 mg tablet
   - ☐ Other: _____

   ***Zepatier (or generic) requires resistance-associated substitutions (RAS) testing.**

2. Select **duration**:
   ☐ 8 weeks ☐ 12 weeks ☐ 16 weeks ☐ Other: _____

3. Restricted Specialist or Consultation with Specialist:
   - ☐ Decompensated cirrhosis (Child Pugh B or C)
   - ☐ Hepatocellular carcinoma (HCC)
   - ☐ Status post-liver transplant
   - ☐ Mixed genotype
   - ☐ Youth ages 12 up to 18
   - ☐ Previous treatment with NS3/4A PI **and** NS5A inhibitor
   - ☐ HBV co-infection

For Patients with Hepatocellular Carcinoma (HCC) Awaiting Liver Transplant

1. Is documentation attached showing patient meets Milan criteria defined as:
   - Presence of a tumor 5 cm or less in diameter in patients with a single tumor; **OR**
   - No more than three tumor nodules, each 3 cm or less in diameter, in patients with multiple tumors; **AND**
   - No extrahepatic manifestations of the cancer and no evidence of vascular invasion of the tumor?

   ☐ Yes ☐ No

2. Is a signed **Patient Readiness Assessment Form** attached?
   ☐ Yes ☐ No

3. Has the patient been evaluated for treatment readiness, identification of potential impediments to successful therapy, including an assessment for current/historical alcohol and substance misuse (e.g., compliance difficulty, missed appointments, inadequate social support, or sub-therapeutic management of comorbid mental and physical health conditions)? Possible tools include SBIRT (SAMHSA), AUDIT-C (WHO), and NM-ASSIST (NIDA).
   ☐ Yes ☐ No

Last Name: _____ First Name: _____

4. If the patient is identified as having barriers to treatment, please acknowledge actions taken by this or another provider involved in the patient's care to address those barriers.
   - ☐ Attending treatment/support program
   - ☐ Referred to treatment/support program
   - ☐ Not attending/not referred to treatment program
   - ☐ Connected with other services/resources
5. Would you like to refer the patient to the Alaska Medicaid Coordinated Care Initiative to help connect them to additional resources?
   ☐ Yes ☐ No
6. Has the patient been provided with education on the effects of alcohol and substance use/misuse on liver and overall health, risks contributing to re-infection, and drug product-specific information?
   ☐ Yes ☐ No
7. Does the patient agree to abstain from alcohol use during treatment?
   ☐ Yes ☐ No
8. I attest that HCV RNA levels will be obtained and maintained for the patient at 12 weeks post-therapy completion and shall be provided upon request.
   ☐ Yes ☐ No
9. Please note any other information pertinent to this PA request including unique circumstances that should be considered:

Attestation: I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Alaska Medicaid.

Prescriber Signature: _____ **Date:** _____

Magellan Medicaid Administration, PA Unit
14100 Magellan Plaza
Maryland Heights, MO 63043
Phone: (800) 331-4475

Fax this form to (888) 603-7696