FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR INCIVEK AND VICTRELIS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Incivek and Victrelis Completion Instructions, F-00583A. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage* for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization Drug Attachment for Incivek and Victrelis form signed and dated by the prescriber before submitting a prior authorization (PA) request. Providers may call Provider Services at (800) 947-9627 with questions.

This form must be completed for initial PA requests *and* renewal PA requests.

Prescriber Responsibilities for Initial Prior Authorization Requests
For initial PA requests, prescribers should do the following:

- Complete **Sections I, II, III, and VI** of this form.
- Submit the completed, signed, and dated form to the pharmacy where the prescription will be filled.

Prescriber Responsibilities for Renewal Prior Authorization Requests
For renewal PA requests, prescribers should do the following:

- Complete **Sections I, II, IV or V, and VI** of this form.
- Submit the completed, signed, and dated form to the pharmacy where the prescription will be filled.

Pharmacy Provider Responsibilities for Initial Prior Authorization Requests
For initial PA requests, pharmacy providers should do the following:

- Complete a Prior Authorization Request Form (PA/RF), F-11018.
- Submit the completed Prior Authorization Drug Attachment for Incivek and Victrelis with the PA/RF to ForwardHealth on the Portal or on paper by fax or mail.

Pharmacy Provider Responsibilities for Renewal Prior Authorization Requests
For renewal PA requests, pharmacy providers should do the following:

- Complete a Prior Authorization Amendment Request, F-11042.
- Submit the completed Prior Authorization Drug Attachment for Incivek and Victrelis with the Prior Authorization Amendment Request to ForwardHealth on the Portal or on paper by fax or mail.

SECTION I — MEMBER INFORMATION — INITIAL AND RENEWAL REQUESTS

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number	3. Date of Birth — Member

SECTION II — PRESCRIPTION INFORMATION — INITIAL AND RENEWAL REQUESTS

4. Drug Name	5. Drug Strength
6. Date Prescription Written	7. Refills

8. Directions for Use

Continued

SECTION II — PRESCRIPTION INFORMATION — INITIAL AND RENEWAL REQUESTS (Continued)

9. Name — Prescriber	10. National Provider Identifier (NPI) — Prescriber

11. Address — Prescriber (Street, City, State, ZIP+4 Code)

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION FOR INCIVEK AND VICTRELIS — INITIAL REQUESTS ONLY

13. Diagnosis Code and Description

14. Indicate the member's hepatitis C genotype in the space below.

15. Is the member 18 years of age or older? ❑ Yes ❑ No

16. Is the member pregnant? ❑ Yes ❑ No

17. Has the member had a liver transplant? ❑ Yes ❑ No

18. Has the member received a prior course of therapy with a treatment regimen that includes the requested agent or any other hepatitis C virus (HCV) NS3/4 protease inhibitor? ❑ Yes ❑ No

If yes, indicate the specific details about the prior course of therapy, the drug name(s), the approximate dates of the prior course of treatment, why treatment was discontinued, and why another course of treatment is being requested in the space below.

19. Indicate the member's most recent hepatitis C virus ribonucleic acid (HCV-RNA) level and the date it was measured.

HCV-RNA Level _____ IU/mL Date Measured _____

20. Is the member currently being treated with pegylated interferon and ribavirin? ❑ Yes ❑ No

If yes, indicate the date treatment with pegylated interferon and ribavirin started. _____

If no, indicate the date treatment with pegylated interferon and ribavirin is anticipated to start _____

21. For Victrelis requests only, indicate the date treatment with Victrelis is anticipated to start. _____

22. Has the member had previous treatment experience with pegylated interferon and ribavirin? ❑ Yes ❑ No

If yes, indicate the member's previous treatment experience by checking one of the following:

- ❑ Member did not achieve a response (null responder) during treatment with pegylated interferon and ribavirin.
- ❑ Member achieved a partial response to treatment with pegylated interferon and ribavirin.
- ❑ Member relapsed (experienced reappearance of serum HCV-RNA after achieving an undetectable level at the conclusion of a course of therapy with pegylated interferon and ribavirin).
- ❑ Member did not complete the full course of treatment.

If the member did not complete the full course of treatment, indicate the reason why in the space below.

Continued

SECTION III — CLINICAL INFORMATION FOR INCIVEK AND VICTRELIS — INITIAL REQUESTS ONLY (Continued)

23. Is the member coinfected with hepatitis B? ❑ Yes ❑ No

24. Is the member coinfected with Human Immunodeficiency Virus (HIV)? ❑ Yes ❑ No

25. If the member is coinfected with hepatitis B or HIV, indicate the prescriber's medical specialty and experience with prescribing and managing HCV NS3/4 protease inhibitors in coinfected members and why treatment with a HCV NS3/4 protease inhibitor is clinically appropriate for the member in the space below.

RENEWAL PRIOR AUTHORIZATION REQUESTS FOR INCIVEK AND VICTRELIS

SECTION IV — CLINICAL INFORMATION FOR INCIVEK — RENEWAL REQUESTS ONLY

26. Indicate the member's HCV-RNA level at treatment week 4 and the date it was measured.

HCV-RNA Level _____ IU/mL Date Measured _____

SECTION V — CLINICAL INFORMATION FOR VICTRELIS — RENEWAL REQUESTS ONLY

27. Indicate the member's HCV-RNA level at treatment week 12 (i.e., at 8 weeks taking Victrelis) and the date it was measured.

HCV-RNA Level _____ IU/mL Date Measured _____

28. Indicate the member's HCV-RNA level at treatment week 24 (i.e., at 20 weeks taking Victrelis) and the date it was measured.

HCV-RNA Level _____ IU/mL Date Measured _____

29. Prior to the current treatment regimen with Victrelis, was the member naïve to treatment with pegylated interferon and ribavirin? ❑ Yes ❑ No

If yes, indicate the member's HCV-RNA level at treatment week 8 (i.e., at 4 weeks taking Victrelis) and the date it was measured.

HCV-RNA Level _____ IU/mL Date Measured _____

SECTION VI — AUTHORIZED SIGNATURE — INITIAL AND RENEWAL REQUESTS

30. **SIGNATURE** — Prescriber	31. Date Signed

SECTION VII — ADDITIONAL INFORMATION — INITIAL AND RENEWAL REQUESTS

32. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.

Reset Form