FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR HEPATITIS C PROTEASE INHIBITORS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Hepatitis C Protease Inhibitors 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 Hepatitis C Protease Inhibitors 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 both initial *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, IIIA, 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 Hepatitis C Protease Inhibitors with the PA/RF to ForwardHealth on the Portal, by fax, or by 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 Hepatitis C Protease Inhibitors with the Prior Authorization Amendment Request to ForwardHealth on the Portal, by fax, or by 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 — Prescriber

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

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION — INITIAL REQUESTS ONLY

13. Diagnosis Code and Description

14. Indicate the member's hepatitis C genotype and subtype.

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 provided.

Continued

SECTION III — CLINICAL INFORMATION — 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 an HCV NS3/4 protease inhibitor is clinically appropriate for the member in the space provided.

SECTION IIIA — CLINICAL INFORMATION FOR OLYSIO — INITIAL REQUESTS ONLY

26. Has the member been tested for the Q80K polymorphism? ☐ Yes ☐ No

If yes, indicate the results in the space provided.

27. Provide detailed clinical justification for prescribing Olysio instead of Incivek or Victrelis, including clinical information why the member cannot use Incivek or Victrelis and why it is medically necessary that the member receive Olysio instead of Incivek or Victrelis.

SECTION IV — CLINICAL INFORMATION FOR INCIVEK OR OLYSIO — RENEWAL REQUESTS ONLY

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

HCV-RNA Level _____ IU/mL Date Measured _____

SECTION V — CLINICAL INFORMATION FOR VICTRELIS — RENEWAL REQUESTS ONLY

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

HCV-RNA Level _____ IU/mL Date Measured _____

30. 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 _____

31. 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 eight (i.e., at four weeks taking Victrelis) and the date it was measured.

HCV-RNA Level _____ IU/mL Date Measured _____

SECTION VI — AUTHORIZED SIGNATURE — INITIAL AND RENEWAL REQUESTS

32. **SIGNATURE** — Prescriber	33. Date Signed

SECTION VII — ADDITIONAL INFORMATION — INITIAL AND RENEWAL REQUESTS

34. 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