FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR HEPATITIS C PROTEASE INHIBITORS COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (DHS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory when requesting a PA for certain drugs. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

INSTRUCTIONS

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 the Prior Authorization Drug Attachment for Hepatitis C Protease Inhibitors, F-00583.
- 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 the Prior Authorization Drug Attachment for Hepatitis C Protease Inhibitors.
- 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.

SUBMITTING PRIOR AUTHORIZATION REQUESTS

Pharmacy providers may submit PA requests on the Prior Authorization Drug Attachment for Hepatitis C Protease Inhibitors form in one of the following ways:

1) For requests submitted on the ForwardHealth Portal, providers may access *www.forwardhealth.wi.gov/*.

2) For PA requests submitted by fax, pharmacy providers should submit either a PA/RF for initial PA requests or a Prior Authorization Amendment Request for renewal PA requests and the Prior Authorization Drug Attachment for Hepatitis C Protease Inhibitors form to ForwardHealth at (608) 221-8616.

3) For PA requests submitted by mail, pharmacy providers should submit either a PA/RF for initial PA requests or a Prior Authorization Amendment Request for renewal PA requests and the Prior Authorization Drug Attachment for Hepatitis C Protease Inhibitors form to the following address:

   ForwardHealth
   Prior Authorization
   Ste 88
   313 Blettner Blvd
   Madison WI 53784

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

Prescribers and pharmacy providers are required to retain a completed copy of the form.

SECTION I — MEMBER INFORMATION — INITIAL AND RENEWAL REQUESTS

Element 1 — Name — Member
Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

Element 3 — Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format.

SECTION II — PRESCRIPTION INFORMATION — INITIAL AND RENEWAL REQUESTS

Element 4 — Drug Name
Enter the name of the drug.

Element 5 — Drug Strength
Enter the strength of the drug.

Element 6 — Date Prescription Written
Enter the date the prescription was written.

Element 7 — Refills
Enter the number of refills.

Element 8 — Directions for Use
Enter the directions for use of the drug.

Element 9 — Name — Prescriber
Enter the name of the prescriber.

Element 10 — National Provider Identifier — Prescriber
Enter the 10-digit National Provider Identifier of the prescriber.

Element 11 — Address — Prescriber
Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 12 — Telephone Number — Prescriber
Enter the telephone number, including area code, of the prescriber.

SECTION III — CLINICAL INFORMATION — INITIAL REQUESTS ONLY

Prescribers are required to complete the appropriate sections before signing and dating the Prior Authorization Drug Attachment for Hepatitis C Protease Inhibitors form.

Element 13 — Diagnosis Code and Description
Enter the appropriate and most-specific *International Classification of Diseases* (ICD) diagnosis code and description most relevant to the drug requested. The ICD diagnosis code must correspond with the ICD description.

Element 14
Indicate the member's hepatitis C genotype and subtype in the space provided.

Element 15
Check the appropriate box to indicate whether or not the member is 18 years of age or older.

Element 16
Check the appropriate box to indicate whether or not the member is pregnant.

Element 17
Check the appropriate box to indicate whether or not the member has had a liver transplant.

Element 18
Check the appropriate box to indicate whether or not the member has 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. 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 provided.

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

Element 20
Indicate whether or not the member is currently being treated with pegylated interferon and ribavirin. If yes, indicate the date treatment with pegylated interferon and ribavirin started in the space provided. If no, indicate the date treatment with pegylated interferon and ribavirin is anticipated to start in the space provided.

Element 21
For Victrelis requests only, indicate the date treatment with Victrelis is anticipated to start in the space provided.

Element 22
Check the appropriate box to indicate whether or not the member has had previous treatment experience with pegylated interferon and ribavirin. If yes, indicate the member's previous treatment experience with pegylated interferon and ribavirin by checking one of the options listed. If the member did not complete the full course of treatment, indicate the reason why in the space provided.

Element 23
Check the appropriate box to indicate whether or not the member is coinfected with hepatitis B.

Element 24
Check the appropriate box to indicate whether or not the member is coinfected with Human Immunodeficiency Virus (HIV).

Element 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

Element 26
Check the appropriate box to indicate whether or not the member has been tested for the Q80K polymorphism. If yes, indicate the results in the space provided.

Element 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

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

SECTION V — CLINICAL INFORMATION FOR VICTRELIS — RENEWAL REQUESTS ONLY

Element 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 in the spaces provided.

Element 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 in the spaces provided.

Element 31
Check the appropriate box to indicate whether or not the member was naïve to treatment with pegylated interferon and ribavirin prior to the current treatment regimen with Victrelis. 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 in the spaces provided.

SECTION VI — AUTHORIZED SIGNATURE — INITIAL AND RENEWAL REQUESTS

Element 32 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 33 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION VII — ADDITIONAL INFORMATION — INITIAL AND RENEWAL REQUESTS

Element 34
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may also be included.