

FORWARDHEALTH
PRIOR AUTHORIZATION DRUG ATTACHMENT FOR HEPATITIS C AGENTS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Hepatitis C Agents Completion Instructions, F-01247A. 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 Agents form signed by the prescriber before submitting a prior authorization (PA) request on the Portal, by fax, or by mail. Providers may call Provider Services at 800-947-9627 with questions.

SECTION I — MEMBER INFORMATION

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

2. Member Identification Number

3. Date of Birth — Member

SECTION II — PRESCRIPTION INFORMATION

4. Date Prescription Written

5. Name — Prescriber

6. National Provider Identifier — Prescriber

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

8. Telephone Number — Prescriber

9. Indicate the member's proposed hepatitis C drug treatment regimen.

Drug Name _____ Daily Dose _____ Expected Duration _____

Currently taking? Yes No If yes, enter the date started. _____

Drug Name _____ Daily Dose _____ Expected Duration _____

Currently taking? Yes No If yes, enter the date started. _____

Drug Name _____ Daily Dose _____ Expected Duration _____

Currently taking? Yes No If yes, enter the date started. _____

SECTION III — CLINICAL INFORMATION

10. Diagnosis Code and Description

Continued



SECTION III — CLINICAL INFORMATION (Continued)

Note: A copy of the current medical records must be submitted with the PA request, including the following:

- Hepatitis C virus (HCV) assessment and treatment plan.
 - Current history and physical, including complete problem and medication list.
 - From the member's primary care provider, a current and past psychosocial history, including alcohol and illicit drug use.
 - Lab data (within the last six months): albumin, complete blood count (CBC), international normalized ratio (INR), liver function tests (LFTs), serum creatinine.
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11. Is the prescriber board certified in gastroenterology or infectious disease? Yes No

If the prescriber is a mid-level practitioner, does the prescriber have a collaborative relationship with a board-certified gastroenterologist or board-certified infectious disease physician?

Yes No

Provide the collaborating physician's name, board specialty, and contact information in the space provided.

12. Provide the date that the member was diagnosed with hepatitis C.

13. Indicate the likely source of the HCV infection.

14. Indicate the member's HCV genotype and subtype.

15. If genotype 1, is Viekira Pak™ being prescribed? Yes No

If no, explain the member's medical or medication contraindication for treatment with Viekira Pak™.

16. Is the member coinfecting with hepatitis A, hepatitis B, or HIV? Yes No

If yes, list the coinfection(s).

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

18. Has the member been counseled on necessary contraception and pregnancy precautions for the member and his or her partner(s) during HCV treatment? Yes No

Note: The current HCV drugs have known and unknown risks of fetal harm and teratogenic effects.

19. Has the member had a liver transplant? Yes No

20. Is the member on a liver transplant wait list? Yes No

If yes, provide the following:

Date the member was added to the transplant list. _____

Member's Current Model for End-Stage Liver Disease (MELD) Score _____ Assessment Date _____

Note: A copy of the liver transplant workup must be submitted with the PA request.

21. Does the member have hepatocellular carcinoma? Yes No

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SECTION III — CLINICAL INFORMATION (Continued)

22. Indicate the member's most recent hepatitis C virus ribonucleic acid (HCV-RNA) level and the date it was taken (must be within the past six months).

HCV-RNA _____ IU / mL Test Date _____

Note: A copy of the results must be submitted with the PA request.

23. Indicate the member's previous hepatitis C drug therapy or check "Hepatitis C Treatment Naïve" if appropriate.

Hepatitis C Treatment Naïve

Drug Name _____ Daily Dose _____ Dates Taken _____

Drug Name _____ Daily Dose _____ Dates Taken _____

Drug Name _____ Daily Dose _____ Dates Taken _____

Drug Name _____ Daily Dose _____ Dates Taken _____

24. List all non-hepatitis C drugs the member is currently receiving or check "None" if appropriate.

None

Drug Name _____ Drug Name _____ Drug Name _____

Drug Name _____ Drug Name _____ Drug Name _____

Drug Name _____ Drug Name _____ Drug Name _____

Drug Name _____ Drug Name _____ Drug Name _____

25. Does the member have a history of alcohol abuse? Yes No

If yes, provide details regarding his or her alcohol abuse history. If the member is currently participating in a recovery program, counseling services, or toxicology screening, and/or if he or she is seeing an addiction specialist, provide details regarding when the member began participation and the specific services the member is receiving.

26. Does the member have a history of illicit drug use? Yes No

If yes, provide details regarding his or her illicit drug use history. If the member is currently participating in a recovery program, counseling services, or toxicology screening, and/or if he or she is seeing an addiction specialist, provide details regarding when the member began participation and the specific services the member is receiving.

27. Has the member had a liver biopsy? Yes No

If yes, provide the following:

Date Taken _____ Scoring System Used (e.g., Metavir) _____

Inflammation Grade (A) _____ Fibrosis Stage (F) _____

Note: A copy of the results must be submitted with the PA request.

Continued

SECTION III — CLINICAL INFORMATION (Continued)

28. Has the member had a liver computed tomography (CT), ultrasound, or MRI? Yes No

If yes, provide the date taken. _____

Note: A copy of the results must be submitted with the PA request.

29. Does the member have cirrhosis of the liver? Yes No

If yes, complete the following:

What is the member's current Child-Turcotte-Pugh (CTP) Score? _____ Date Calculated _____

Is the member abstinent from alcohol? Yes No

When did the member last consume alcohol? _____

Does the member have or is he or she being treated for the following:

- Ascites Yes No
- Esophageal varices Yes No
- Hepatic encephalopathy Yes No
- Jaundice Yes No
- Portal hypertension Yes No

SECTION IV — AUTHORIZED SIGNATURE

30. SIGNATURE — Prescriber

31. Date Signed

SECTION V — ADDITIONAL INFORMATION

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.
