FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR HEPATITIS C AGENTS COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to authorize and pay for medical services provided to eligible members. Although these instructions refer to BadgerCare Plus, all information also applies to Medicaid.

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 (Wis. Admin. Code § DHS 104.02[4]).

Under Wis. Stats. § 49.45(4), 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 PA for certain drugs. 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
Prescribers are required to complete and sign the Prior Authorization Drug Attachment for Hepatitis C Agents, F-01247. Pharmacy providers are required to use the Prior Authorization Drug Attachment for Hepatitis C Agents form to request PA by submitting a PA request on the ForwardHealth Portal, by fax, or by mail. Prescribers and pharmacy providers are required to retain a completed copy of the form.

Providers may submit PA requests on a PA drug attachment form in one of the following ways:

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

2) For PA requests submitted by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate PA attachment to ForwardHealth at 608-221-8616.

3) For PA requests by mail, pharmacy providers should submit a PA/RF and the appropriate PA drug attachment 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).

SECTION I — MEMBER INFORMATION

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

Element 4 — Date Prescription Written
Enter the date the prescription was written.

Element 5 — Name — Prescriber
Enter the name of the prescribing provider.

Element 6 — National Provider Identifier — Prescriber
Enter the prescribing provider's 10-digit National Provider Identifier.

Element 7 — Address — Prescriber
Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 8 — Telephone Number — Prescriber
Enter the telephone number, including area code, of the prescriber.

Element 9
Indicate the drug name, daily dose, and expected duration for the proposed hepatitis C drug treatment regimen. Indicate whether or not the member is currently taking the drug. If the member is currently taking this drug, enter the date started.

SECTION III — CLINICAL INFORMATION

Element 10 — 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.

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, including psychosocial history.
- Assessment of other significant or uncontrolled diseases, including complete problem list.
- Complete medication list.
- Lab data: Liver function tests, complete blood count, serum creatinine, albumin, international normalized ratio.

Element 11
Indicate whether or not the prescriber is board certified in gastroenterology or board certified in infectious disease. If the prescriber is a mid-level practitioner, indicate whether or not he or she has a collaborative relationship with a board-certified gastroenterologist or board-certified infectious disease physician. Provide the collaborating physician's name, board specialty, and contact information in the space provided.

Element 12 — Date Member Was Diagnosed with Hepatitis C
Provide the date (in MM/DD/CCYY format) that the member was diagnosed with hepatitis C.

Element 13
Indicate the likely source of the HCV infection in the space provided.

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

Element 15
If the member has HCV genotype 1, indicate whether or not Viekira Pak™ is being prescribed. If Viekira Pak™ is not being prescribed, explain the member's medical or medication contraindication for treatment.

Element 16
Check the appropriate box to indicate whether or not the member is coinfected with hepatitis A, hepatitis B, or HIV. If yes, list the member's coinfection(s).

Element 17
Check the appropriate box to indicate whether or not the member is 18 years of age or older.

Element 18
Indicate whether or not the member has been counseled on the necessary contraception and pregnancy precautions for the member and his or her partner(s) during HCV treatment.

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

Element 19
Check the appropriate box to indicate whether or not the member has had a liver transplant.

Element 20
Check the appropriate box to indicate whether or not the member is on a liver transplant wait list. If yes, provide the date the member was added to the transplant list, the member's current Model for End-Stage Liver Disease (MELD) score, and the assessment date.

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

Element 21
Check the appropriate box to indicate whether or not the member has hepatocellular carcinoma.

Element 22
Indicate the member's most recent hepatitis C virus ribonucleic acid (HCV-RNA) level and the date it was taken in the spaces provided.

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

Element 23
Indicate the drug name, daily dose, and dates taken for the member's previous hepatitis C drug therapy. Check "Hepatitis C Treatment Naïve" if appropriate.

Element 24
List all of the drug names for all non-hepatitis C drugs the member is currently receiving. Check "None" if appropriate.

Element 25
Check the appropriate box to indicate whether or not the member has a history of alcohol abuse. 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.

Element 26
Check the appropriate box to indicate whether or not the member has a history of illicit drug use. If yes, provide details regarding his or her illicit drug use history. If he or she 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.

Element 27
Check the appropriate box to indicate whether or not the member has had a liver biopsy. If yes, in the spaces provided list the date taken, the scoring system used (e.g., Metavir), the inflammation grade (A), and the fibrosis stage (F).

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

Element 28
Check the appropriate box to indicate whether or not the member has had a liver computed tomography (CT), ultrasound, or MRI. If yes, provide the date taken.

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

Element 29
Check the appropriate box to indicate whether or not the member has cirrhosis of the liver. If yes, indicate the following:
- The member's current Child-Turcotte-Pugh (CTP) score and the date calculated.
- Whether or not the member is abstinent from alcohol and when he or she last consumed alcohol.
- Whether or not the member has been treated or is being treated for ascites, esophageal varices, hepatic encephalopathy, jaundice, or portal hypertension.

SECTION IV — AUTHORIZED SIGNATURE

Element 30 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 31 — Date Signed
Indicate the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION V — ADDITIONAL INFORMATION

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