DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-01247 (01/2017)

STATE OF WISCONSIN
Wis. Admin. Code § DHS 107.10(2)

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 (Required for all PA requests.)

10. Diagnosis Code and Description

Continued

DT-PA109-109

SECTION III – CLINICAL INFORMATION (Required for all PA requests.) (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
- Current and past psychosocial history, including alcohol and illicit drug use, from the member's primary care provider
- Lab data (within the last six months) for albumin, complete blood count (CBC), international normalized ratio (INR), liver function tests (LFTs), and serum creatinine

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 following information for the collaborating physician.

    Name _____ Specialty _____

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. The following are preferred drugs for members with the following HCV infection:
    - **Genotype 1:** Viekira Pak™ / Viekira XR™ or Zepatier™
    - **Genotype 2:** Epclusa®
    - **Genotype 3:** Epclusa®
    - **Genotype 4:** Technivie™ or Zepatier™

    Note: For Zepatier™, members with genotype 1a **must** be screened for the presence of NS5A polymorphisms. A copy of the results **must** be submitted with the PA request.

    For members with HCV genotype 1, 2, 3, or 4, is a preferred drug being prescribed? ☐ Yes ☐ No

    If no, explain the member's medical or medication contraindication for treatment with the preferred drug(s) for the member's HCV infection.

16. Is the member coinfected with HIV? ☐ Yes ☐ No

    If yes, indicate the member's most recent HIV viral load, CD4 count, and the date taken.

    Viral Load _____ copies / mL Test Date _____

    CD4 Count _____ Test Date _____

17. Does the member have a current or previous infection with hepatitis A? ☐ Yes ☐ No

18. Does the member have a current or previous infection with hepatitis B? ☐ Yes ☐ No

    If yes, will the prescriber screen and monitor for hepatitis B virus reactivation during HCV treatment? ☐ Yes ☐ No

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

Continued

SECTION III – CLINICAL INFORMATION (Required for all PA requests.) (Continued)

20. 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.

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

22. 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.

23. Does the member have hepatocellular carcinoma? ❑ Yes ❑ No

24. 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 Date Taken _____

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

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

❑ Hepatitis C Treatment Naïve

Drug Name _____ Dates Taken _____ Treatment Results _____

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Drug Name _____ Dates Taken _____ Treatment Results _____

26. 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.

27. 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.

Continued

SECTION III – CLINICAL INFORMATION (Required for all PA requests.) (Continued)

28. 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.

29. Has the member had a Fibroscan, MR elastography, or ultrasound elastography of the liver? ☐ Yes ☐ No

If yes, provide the following:

Type of Study _____ Date Taken _____ Result _____ Fibrosis Stage (F) _____

Type of Study _____ Date Taken _____ Result _____ Fibrosis Stage (F) _____

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

30. Has the member had a computed tomography (CT), ultrasound, or MRI of the abdomen? ☐ Yes ☐ No

If yes, provide the following:

Type of Study _____ Date Taken _____

Type of Study _____ Date Taken _____

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

31. Does the member have cirrhosis? ☐ Yes ☐ No

If the member has cirrhosis, then complete Section III A.

SECTION III A – CLINICAL INFORMATION REQUIRED FOR MEMBERS WITH CIRRHOSIS ONLY

32. For members with cirrhosis, indicate the following:

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? _____

Has the member had a screening for hepatocellular carcinoma with a CT, ultrasound, or MRI of the abdomen within the last six months? ☐ Yes ☐ No

Note: A copy of the radiology report **must** be submitted with the PA request.

33. 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

Continued

SECTION IV – AUTHORIZED SIGNATURE	
34. **SIGNATURE** – Prescriber	35. Date Signed

SECTION V – ADDITIONAL INFORMATION

36. 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