DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01247 (01/2018)

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 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 ID 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

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
- Current and past psychosocial history, including alcohol and IV drug use
- Lab tests performed (within the last **six months**): albumin, complete blood count (CBC), international normalized ratio (INR), liver function tests (LFTs), serum creatinine, and HCV-ribonucleic acid (HCV-RNA) level

11. Provide the date that the member was diagnosed with HCV and indicate the likely source of the HCV Infection.

Date _____ Source _____

12. Indicate the member's HCV genotype and subtype and the HCV-RNA level and the date(s) performed.

HCV genotype and subtype _____ Date _____

HCV-RNA level _____ IU/mL Date _____

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

13. Has the member recently been screened for hepatitis B virus (HBV)? ❑ Yes ❑ No

If yes, date performed _____

14. Has the member received a liver transplant? ❑ Yes ❑ No

15. The following are preferred drugs for members with the following HCV infection:

- **Genotype 1:** Epclusa®, Harvoni®, Mavyret™, Viekira Pak™ / Viekira XR™, or Zepatier®
- **Genotype 2:** Epclusa®, Mavyret™
- **Genotype 3:** Epclusa®, Mavyret™
- **Genotype 4:** Epclusa®, Harvoni®, Mavyret™, or Zepatier®
- **Genotype 5:** Epclusa®, Harvoni®, Mavyret™
- **Genotype 6:** Epclusa®, Harvoni®, Mavyret™

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

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).

16. 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 _____

Drug Name _____ Dates Taken _____ Treatment Results _____

Drug Name _____ Dates Taken _____ Treatment Results _____

Drug Name _____ Dates Taken _____ Treatment Results _____

17. Does the member have a history of an alcohol use disorder? ❑ Yes ❑ No

Date the member last consumed alcohol. _____

18. Does the member have a history of IV drug use? ❑ Yes ❑ No

If yes, provide the date the member last used IV drugs. _____

Continued

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

19. Has the member been or is the member currently a participant in a recovery program? ❑ Yes ❑ No

If yes, provide details in the space provided.

20. Has the member had a liver biopsy, imaging studies, or blood assay tests to determine hepatic fibrosis? ❑ Yes ❑ No

If yes, provide the following:

Test Performed _____ Fibrosis Stage (F) _____ Date _____

Test Performed _____ Fibrosis Stage (F) _____ Date _____

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

21. Does the member have cirrhosis? ❑ Yes ❑ No

If the member has cirrhosis, Section III A **must** be completed.

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

22. Indicate the member's current Child-Turcotte-Pugh (CTP) class, score, and the date calculated.

Class _____ Score _____ Date Calculated _____

23. Does the member have or is the member being treated for the following conditions?

- Ascites ❑ Yes ❑ No
- Hepatic encephalopathy ❑ Yes ❑ No
- Portal hypertension ❑ Yes ❑ No
- Hepatocellular cancer ❑ Yes ❑ No

24. Has the member had an imaging study to screen for hepatocellular carcinoma within the past six months? ❑ Yes ❑ No

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

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

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

SECTION IV – AUTHORIZED SIGNATURE

26. **SIGNATURE** – Prescriber	27. Date Signed

SECTION V – ADDITIONAL INFORMATION

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