DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01247 (07/2017)

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 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

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
- Current and past psychosocial history, including alcohol and IV drug use
- Lab data (within the last six months) for albumin, complete blood count (CBC), international normalized ratio (INR), liver function tests (LFTs), and serum creatinine
- Hepatitis B virus (HBV) screening

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

12. Indicate the likely source of the HCV infection.

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

14. 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 resistance-associated 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.

15. 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 _____

16. Has the member received a liver transplant? ☐ Yes ☐ No

17. Does the member have current or past history of hepatocellular carcinoma? ☐ Yes ☐ No

18. 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.

19. 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 _____

Continued

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

20. Does the member have a history of an alcohol use disorder? ☐ Yes ☐ No

    Date the member last consumed alcohol. _____

21. Does the member have a history of IV drug use? ☐ Yes ☐ No

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

22. 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.

23. 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.

24. 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) _____

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

25. Has the member had a blood test to assess hepatic fibrosis (e.g., FibroTest, FibroSure, FibroSpect)? ☐ Yes ☐ No

    If yes, provide the following:

    Type of Blood Test _____Date Taken _____ Result _____ Fibrosis Stage (F) _____

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

26. 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.

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

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

Continued

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

28. The member's current Child-Turcotte-Pugh (CTP) Score _____ Date Calculated _____

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

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

30. 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.

31. 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.

SECTION IV – AUTHORIZED SIGNATURE

32. **SIGNATURE** – Prescriber	33. Date Signed

SECTION V – ADDITIONAL INFORMATION

34. 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