DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01247 (07/2019)

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/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms 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. Phone 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. _____

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

10. Diagnosis Code and Description

Note: A copy of the member's medical records that document the following must be submitted with the PA request:

- Hepatitis C virus (HCV) assessment and treatment plan
- Current history and physical, including complete problem and medication list
- Lab tests performed (within the last **six months**): albumin, complete blood count (CBC), international normalized ratio (INR), liver function panel, 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. Indicate the member's previous HCV treatment.

    Is the member HCV treatment naïve? ❑ Yes ❑ No

    Has the member had previous pegylated interferon/ribavirin treatment or direct-acting antiviral (DAA) HCV treatment? ❑ Yes ❑ No

    If the member has received previous HCV treatment, provide the following:

    Drug Name _____ Dates Taken _____ Treatment Results _____

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14. 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 _____

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

15. 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

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

    Class _____ Score _____ Date Calculated _____

17. 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

18. Has the member had medical imaging to screen for hepatocellular carcinoma within the past six months? ❑ Yes ❑ No

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

SECTION IV – AUTHORIZED SIGNATURE

19. **SIGNATURE** – Prescriber	20. Date Signed

SECTION V – ADDITIONAL INFORMATION

21. 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