**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services Wis. Admin. Code § DHS 107.10(2)

F-01247 (07/2020)

**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](https://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.

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| **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, international normalized ratio, liver function panel, serum creatinine, and HCV-ribonucleic acid (HCV-RNA) level | | |

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| 11. Is there a clinically significant drug interaction between another drug the member is  taking and the preferred drugs?  Yes  No  If yes, list the drug(s) and interaction(s). | |
| 12. Does the member have a medical condition(s) that prevents the use of the preferred drugs?  Yes  No  If yes, list the medical condition(s), and describe how the condition(s) prevents the member from using the preferred drug(s). | |
| 13. Provide the date that the member was diagnosed with HCV, and indicate the likely source of the HCV Infection.  Date       Source | |
| 14. 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. | |
| 15. Indicate the member’s previous HCV treatment.  Has the member had previous pegylated interferon/ribavirin treatment or direct-acting  antiviral HCV treatment?  Yes  No  If the member has received previous HCV treatment, provide the following:  Drug Name       Date(s) Taken       Treatment Results  Drug Name       Date(s) Taken       Treatment Results  Drug Name       Date(s) Taken       Treatment Results | |
| 16. 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       Date  **Note:**A copy of the results **must** be submitted with the PA request. | |
| 17. 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** | |
| 18. Indicate the member’s current Child-Turcotte-Pugh class and score and the date calculated.  Class       Score       Date Calculated | |
| 19. Does the member have or is the member being treated for the following conditions?   * Ascites  Yes  No * Hepatic encephalopathy  Yes  No * Hepatocellular cancer  Yes  No * Portal hypertension  Yes  No | |
| 20. 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** | | |
| 21. **SIGNATURE** – Prescriber | 22. Date Signed | |
| **SECTION V – ADDITIONAL INFORMATION** | | |
| 23. 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. | | |