**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 [ ]  NoIf yes, list the drug(s) and interaction(s).      |
| 12. Does the member have a medical condition(s) that prevents the use of thepreferred drugs? [ ]  Yes [ ]  NoIf 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 [ ]  NoIf 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 [ ]  NoIf 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 [ ]  NoIf 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.      |