DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01247 (07/2020)

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. _____

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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

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 _____

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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.

Reset Form