FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR HEPATITIS C AGENTS COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to authorize and pay for medical services provided to eligible members. Although these instructions refer to BadgerCare Plus, all information also applies to Medicaid.

Members of ForwardHealth programs are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. Per Wis. Admin. Code § DHS 104.02(4), this information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member ID number.

Under Wis. Stat. § 49.45(4), personally identifiable information about program applicants and members is confidential and is only used for purposes directly related to ForwardHealth administration, such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory when requesting PA for certain drugs. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization Drug Attachment for Hepatitis C Agents, F-01247. Pharmacy providers are required to use the Prior Authorization Drug Attachment for Hepatitis C Agents form to request PA by submitting a PA request on the ForwardHealth Portal, by fax, or by mail. Prescribers and pharmacy providers are required to retain a completed copy of the form.

Providers may submit PA requests on a PA drug attachment form in one of the following ways:

1) For requests submitted on the ForwardHealth Portal, pharmacy providers can access *www.forwardhealth.wi.gov/.*

2) For PA requests submitted by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate PA attachment to ForwardHealth at 608-221-8616.

3) For PA requests by mail, pharmacy providers should submit a PA/RF and the appropriate PA drug attachment form to the following address:

   ForwardHealth
   Prior Authorization
   Ste 88
   313 Blettner Blvd
   Madison WI 53784

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I – MEMBER INFORMATION

Element 1 – Name – Member
Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth ID card and the EVS do not match, use the spelling from the EVS.

Element 2 – Member ID Number
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

Element 3 – Date of Birth – Member
Enter the member's date of birth in MM/DD/CCYY format.

SECTION II – PRESCRIPTION INFORMATION

Element 4 – Date Prescription Written
Enter the date the prescription was written.

Element 5 – Name – Prescriber
Enter the name of the prescribing provider.

Element 6 – National Provider Identifier – Prescriber
Enter the prescribing provider's 10-digit National Provider Identifier.

Element 7 – Address – Prescriber
Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 8 – Telephone Number – Prescriber
Enter the telephone number, including area code, of the prescriber.

Element 9
Indicate the drug name, daily dose, and expected duration for the proposed hepatitis C drug treatment regimen. Indicate whether or not the member is currently taking the drug. If the member is currently taking this drug, enter the date started.

SECTION III – CLINICAL INFORMATION

Element 10 – Diagnosis Code and Description
Enter the appropriate and most-specific *International Classification of Diseases* (ICD) diagnosis code and description most relevant to the drug requested. The ICD diagnosis code must correspond with the ICD description.

***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

Element 11
Provide the date (in MM/DD/CCYY format) that the member was diagnosed with hepatitis C.

Element 12
Indicate the likely source of the HCV infection in the space provided.

Element 13
Indicate the member's HCV genotype and subtype in the space provided.

Element 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.

If the member has HCV genotype 1, 2, 3, or 4, indicate whether or not a preferred drug is being prescribed. If no, explain the member's medical or medication contraindication for treatment with the preferred drug(s) for the member's HCV infection.

Element 15
Check the appropriate box to indicate whether or not the member is coinfected with HIV. If yes, indicate the member's most recent HIV viral load, CD4 count, and the date taken in the spaces provided.

Element 16
Check the appropriate box to indicate whether or not the member has had a liver transplant.

Element 17
Check the appropriate box to indicate whether or not the member has a current or past history of hepatocellular carcinoma.

Element 18
Indicate the member's most recent hepatitis C virus ribonucleic acid (HCV-RNA) level and the date it was taken in the spaces provided.

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

Element 19
Indicate the drug name, dates taken, and treatment results for the member's previous hepatitis C drug therapy. Check "Hepatitis C Treatment Naïve" if appropriate.

Element 20
Check the appropriate box to indicate whether or not the member has a history of alcohol use disorder. Provide the date the member last consumed alcohol.

Element 21
Check the appropriate box to indicate whether or not the member has a history of IV drug use. If yes, provide the date the member last used IV drugs.

Element 22
Check the appropriate box to indicate whether or not the member has been or is currently a participant in a recovery program. If yes, provide details in the space provided.

Element 23
Check the appropriate box to indicate whether or not the member has had a liver biopsy. If yes, list the date taken, the scoring system used (e.g., Metavir), the inflammation grade (A), and the fibrosis stage (F) in the spaces provided.

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

Element 24
Check the appropriate box to indicate whether or not the member has had a Fibroscan, MR elastography, or ultrasound elastography of the liver. If yes, provide the type of study, the date taken, the result, and the Fibrosis stage (F) in the spaces provided.

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

Element 25
Check the appropriate box to indicate whether or not the member has had a blood test to assess hepatic fibrosis (e.g., FibroTest, FibroSure, FibroSpect)? If yes, provide the type of blood test, the date taken, the result, and the Fibrosis State (F) in the spaces provided.

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

Element 26
Check the appropriate box to indicate whether or not the member has had a liver computed tomography (CT), ultrasound, or MRI of the abdomen. If yes, provide the type of study and date taken.

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

Element 27
Check the appropriate box to indicate whether or not the member has cirrhosis. If yes, complete Section III A.

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

Element 28
If the member has cirrhosis, indicate the member's current Child-Turcotte-Pugh (CTP) score and the date calculated.

Element 29
Check the appropriate box to indicate whether or not the member has been treated or is being treated for ascites, esophageal varices, hepatic encephalopathy, jaundice, and portal hypertension.

Element 30
Check the appropriate box to indicate whether or not the member has had a screening for hepatocellular carcinoma with a CT, ultrasound, or MRI of the abdomen in the last six months.

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

Element 31
Check the appropriate box to indicate whether or not the member is on a liver transplant wait list. If yes, provide the date the member was added to the transplant list, the member's current Model for End-Stage Liver Disease (MELD) score, and the assessment date.

Note: A copy of the liver transplant workup **must** be submitted with the PA request.

SECTION IV – AUTHORIZED SIGNATURE

Element 32 – Signature – Prescriber
The prescriber is required to complete and sign this form.

Element 33 – Date Signed
Indicate the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION V – ADDITIONAL INFORMATION

Element 34
Include any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included.