

## 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/](http://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 identification card and the EVS do not match, use the spelling from the EVS.

#### Element 2 – Member Identification 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, from the member's primary care provider
- Current and past psychosocial history, including alcohol and illicit drug use, from the member's primary care provider
- Lab data (within the last six months) for albumin, complete blood count (CBC), international normalized ratio (INR), liver function tests (LFTs), and serum creatinine

**Element 11**

Indicate whether or not the prescriber is board certified in gastroenterology or board certified in infectious disease. If the prescriber is a mid-level practitioner, indicate whether or not he or she has a collaborative relationship with a board-certified gastroenterologist or board-certified infectious disease physician. Provide the collaborating physician's name, board specialty, and contact information in the space provided.

**Element 12**

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

**Element 13**

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

**Element 14**

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

**Element 15**

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 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 16**

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

**Element 17**

Check the appropriate box to indicate whether or not the member has a current or previous infection with hepatitis A.

**Element 18**

Check the appropriate box to indicate whether or not the member has a current or previous infection with hepatitis B. If yes, indicate whether or not the prescriber will screen and monitor for hepatitis B virus reactivation during HCV treatment.

**Element 19**

Check the appropriate box to indicate whether or not the member is 18 years of age or older.

**Element 20**

Check the appropriate box to indicate whether or not the member has been counseled on the necessary contraception and pregnancy precautions for the member and his or her partner(s) during HCV treatment.

*Note:* The current HCV drugs have known and unknown risks of fetal harm and teratogenic effects.

**Element 21**

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

**Element 22**

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.

**Element 23**

Check the appropriate box to indicate whether or not the member has hepatocellular carcinoma.

**Element 24**

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 25**

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 26**

Check the appropriate box to indicate whether or not the member has a history of alcohol abuse. If yes, provide details regarding his or her alcohol abuse history. If the member is currently participating in a recovery program, counseling services, or toxicology screening, and/or if he or she is seeing an addiction specialist, provide details regarding when the member began participation and the specific services the member is receiving.

**Element 27**

Check the appropriate box to indicate whether or not the member has a history of illicit drug use. If yes, provide details regarding his or her illicit drug use history. If he or she is currently participating in a recovery program, counseling services, or toxicology screening, and/or if he or she is seeing an addiction specialist, provide details regarding when the member began participation and the specific services the member is receiving.

**Element 28**

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

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

**Element 29**

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

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

**Element 30**

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 31**

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 32**

If the member has cirrhosis, indicate the following:

- The member's current Child-Turcotte-Pugh (CTP) score and the date calculated.
- Whether or not the member is abstinent from alcohol and when he or she last consumed alcohol.
- Whether or not the member has had a screening for hepatocellular carcinoma with a CT, ultrasound, or MRI of the abdomen within the last six months.

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

**Element 33**

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.

**SECTION IV – AUTHORIZED SIGNATURE**

**Element 34 – Signature – Prescriber**

The prescriber is required to complete and sign this form.

**Element 35 – Date Signed**

Indicate the month, day, and year the form was signed in MM/DD/CCYY format.

**SECTION V – ADDITIONAL INFORMATION**

**Element 36**

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