

**Alaska Medicaid Prior Authorization Form
Hepatitis C Direct Acting Antivirals – New Starts (effective 10/1/17)**

Fax this request to: 1-888-603-7696

Questions: Call Magellan Medicaid Administration at 800-331-4475

Or mail this request to: Medicaid PA Unit, 14100 Magellan Plaza, Maryland Heights, MO 63043

Last Name:	ID Number:
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Clinical Criteria Documentation

1. What is the diagnosis for which this drug is being requested? **(please attach documentation)**

<input type="checkbox"/> Chronic Hepatitis C, genotype 1a	<input type="checkbox"/> Chronic Hepatitis C, genotype 5
<input type="checkbox"/> Chronic Hepatitis C, genotype 1b	<input type="checkbox"/> Chronic Hepatitis C, genotype 6
<input type="checkbox"/> Chronic Hepatitis C, genotype 2	<input type="checkbox"/> Chronic Hepatitis C, mixed genotypes: _____
<input type="checkbox"/> Chronic Hepatitis C, genotype 3	<input type="checkbox"/> Hepatocellular Carcinoma awaiting liver transplant
<input type="checkbox"/> Chronic Hepatitis C, genotype 4	<input type="checkbox"/> Other _____

2. Is the requesting prescriber an Alaska Medicaid provider? Yes No

3. Has the patient had prior treatment for Chronic Hepatitis C? Yes No

a. If yes, please list regimen and dates below:

Prior Hepatitis C Regimen(s):	Inclusive Dates:	Prior Regimen completed?	If discontinued early, state the reason:

4. Metavir Fibrosis Score, equivalent **(attach documentation)**
 Unknown F2
 F0 F3
 F1 F4

5. Does the patient have extrahepatic manifestations of Chronic Hepatitis C, the etiology of which can only be attributable to the HCV infection? If yes, specify which manifestations, and submit documentation. Yes No

6. Baseline HCV Viral Load **(attach documentation)**: IU/mL Date:

7. Child-Pugh Score: Points:
 A
 B
 C

8. Current (within previous 90 days) renal function (creatinine clearance or GFR, estimated): mL/min

9. Is patient HIV co-infected? Yes No

10. Patient has been screened for HBV (HBsAg and anti-HBc) Yes No

HBV status Positive; Negative
refer to specialist

11. If patient is female, patient has been screened and counseled on pregnancy. Yes / not pregnant No

12. Is a current list of all of the patient's medications attached? **(attach documentation)** Yes No

The list should include all scheduled maintenance and as needed (PRN) medications the patient will be taking while on HCV therapy.

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Prescriber Specialty:	Specialty of Consultant Prescriber (if applicable):
<input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Hepatologist <input type="checkbox"/> Infectious Disease Specialist <input type="checkbox"/> Internal Med <input type="checkbox"/> Family Med <input type="checkbox"/> Other _____	<input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Hepatologist <input type="checkbox"/> Infectious Disease Specialist <input type="checkbox"/> Other _____ <input type="checkbox"/> No other prescriber was consulted Specialist Consulted if not prescriber: _____

Requested Regimen			
Requested Regimen	Regimen	Duration	Restricted to Specialist or Consultation with Specialist (identify specialist above)
<input type="checkbox"/>	Mavyret	<input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> 16 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> Decompensated Cirrhosis (Child Pugh B or C) <input type="checkbox"/> Hepatocellular Carcinoma (HCC) <input type="checkbox"/> Status Post Liver Transplant <input type="checkbox"/> Mixed Genotype <input type="checkbox"/> Youth ages 12 up to 18 <input type="checkbox"/> Previous treatment with both an NS3/4A PI and an NSSA inhibitor <input type="checkbox"/> HBV Coinfection
<input type="checkbox"/>	Epclusa		
<input type="checkbox"/>	Zepatier [§]		
<input type="checkbox"/>	Other:		

[§]Requires baseline resistance-associated substitutions (RAS) testing

Resistance-Associated Substitutions (RAS) Testing in Treatment Experienced Patients and Per FDA-Label		
If retreatment, is resistance testing documentation attached? <i>(required)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the product you selected require RAS testing in treatment-naïve individuals?	<input type="checkbox"/> Yes <i>(attach results)</i>	<input type="checkbox"/> No
Resistance-associated substitutions identified <i>(attach results)</i>	<input type="checkbox"/> Yes <i>(attach results)</i>	<input type="checkbox"/> No
Variants Identified:		

For Patients with Hepatocellular Carcinoma (HCC) Awaiting Liver Transplant		
Documentation is attached showing patient meets Milan criteria defined as: <ul style="list-style-type: none"> • The presence of a tumor 5cm or less in diameter in patients with a single tumor OR • No more than three tumor nodules, each 3cm or less in diameter, in patients with multiple tumors AND • No extrahepatic manifestations of the cancer and no evidence of vascular invasion of the tumor. 	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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13. Is a signed Patient Readiness Assessment Form attached?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. The patient has been evaluated for treatment readiness, identification of potential impediments to successful therapy, including an assessment for current/historical alcohol and substance misuse (e.g., compliance difficulty, missed appointments, inadequate social support, or sub-therapeutic management of comorbid mental and physical health conditions). Possible tools include SBIRT (SAMHSA), AUDIT-C (WHO), NM-ASSIST (NIDA).	<input type="checkbox"/> Yes <input type="checkbox"/> No
14a. If patient is identified as having barriers to treatment, please acknowledge actions taken by this or another provider involved in the patient’s care to address those barriers.	<input type="checkbox"/> Attending treatment/support program <input type="checkbox"/> Referred to treatment/support program <input type="checkbox"/> Not attending / not referred to treatment program <input type="checkbox"/> Connected with other services/resources
14b. I would like to refer the patient to the Alaska Medicaid Coordinated Care Initiative to help connect her/him to additional resources (http://dhss.alaska.gov/dhcs/Pages/amcci/providers.aspx).	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. The patient has been provided with education on the effects of alcohol and substance use/misuse on liver and overall health, risks contributing to re-infection, and drug product specific information.	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. The patient agrees to abstain from alcohol use during treatment.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please note any other information pertinent to this PA request including unique circumstances that should be considered:

	Prescriber Initials	<u><i>I attest that HCV RNA levels will be obtained and maintained for patient at 12-weeks post-therapy completion and shall be provided upon request.</i></u>

Direct Prescriber Signature (Required) – No surrogates

Date

(By signature, the Prescriber confirms the above information is accurate and verifiable by patient records.)

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Patient Readiness Assessment Attestation – HCV DAA

(Optional form: prescribers may use a self-generated form if part of standard clinic protocol)

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Please file signed version in patient chart and provide copy to patient; fax copy to Magellan Medicaid with Prior Authorization request.

Please allow 3 days for prior authorization processing.

Member Information

LAST NAME:	FIRST NAME:
<input type="text"/>	<input type="text"/>
ID NUMBER:	DATE OF BIRTH:
<input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>
SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	

Prescriber Information

LAST NAME:	FIRST NAME:
<input type="text"/>	<input type="text"/>
PHONE NUMBER:	
<input type="text"/> - <input type="text"/> - <input type="text"/>	

Patient

	INITIALS	
1.		I am ready to start treatment for the hepatitis C virus.
2.		It is important to take my medication as prescribed for successful treatment.
3.		My doctor gave me information about possible side effects.
4.		I know to call my doctor if I have side effects when taking my medication.
5.		My doctor knows all of the medications I am currently taking (including over-the-counter and herbal products).
6.		I will call my doctor if I start taking a new medication.
7.		I am female. I know that I should avoid becoming pregnant while taking this medication.
8.		I know drinking alcohol or misusing opioids or other drugs can hurt my liver.
9.		My doctor gave me information on where I can find answers for questions about alcohol and opioid or other drug misuse.
10.		My doctor explained what activities to avoid so I do not get infected with the hepatitis C virus again.
11a.		I feel I have the support I need for successful treatment.
11b.		I feel like I need some additional support for successful treatment of my Hepatitis C or another condition I have.
12.		I would like someone from the Alaska Medicaid Coordinated Care Initiative to call me. I would like help connecting to resources or getting answers to questions I have http://dhss.alaska.gov/dhcs/Pages/amcci/members.aspx .

Medication: _____

Treatment Dates: ____ / ____ / ____ through ____ / ____ / ____ (# of weeks: _____)

Patient's Signature _____ Date: _____

Prescriber's Signature _____ Date: _____

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