

Alaska Medicaid Prior Authorization Form Hepatitis C Direct Acting Antivirals – New Starts (effective 7/1/16)

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

If the following information is not complete, correct, or legible, the PA process can be delayed or the request may be denied. Use one form per member please.

Member Information

LAST NAME:

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FIRST NAME:

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ID NUMBER:

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DATE OF BIRTH:

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Prescriber Information

LAST NAME:

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FIRST NAME:

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NPI NUMBER:

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SPECIALTY:

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PHONE NUMBER:

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FAX NUMBER:

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Pharmacy Information

NAME:

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NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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INSTRUCTIONS TO THE PROVIDER- Please note the following criteria for approval and for denial of Hepatitis C direct acting antivirals (DAA):

Clinical Criteria: <http://dhss.alaska.gov/dhcs/Pages/pharmacy/medpriorauthoriz.aspx>

Additional Information

- All questions must be answered or the prior authorization (PA) request will be considered incomplete.
- If incomplete information is submitted, prescribers will have 7 calendar days to respond to the request for additional information, or the request will be non-clinically denied due to lack of information. A re-review is possible with the submittal of a new complete PA request.
- Authorizations will not be approved for more than 12 weeks at a time; it is the prescriber's responsibility to ensure a renewal authorization is submitted in time to allow for the renewal authorization to process.
- Claims will not be approved for more than a 28 day supply; daily quantity limits are as follows:
 - Daklinza – One tablet per day (28 tablets/28 days) in combination with Sovaldi (sofosbuvir)
 - Harvoni – One tablet per day (28 tablets/28 days)
 - Sovaldi – One tablet per day (28 tablets/28 days)
 - Technivie – Two tablets per day (56 tablets/28 days)
 - Viekira Pak – Four tablets per day (112 tablets / 28 days)
 - Zepatier – One tablet per day (28 tablets/28 days)
- Renewal authorizations will require results from an HCV RNA titer at treatment weeks 4 and 8 (if regimen is longer than 12 weeks). HCV RNA results from 12 and 24 weeks post-treatment (SVR 12, SVR 24) are required to be maintained in the medical record, to be made available at the State of Alaska's request.
- Lost or stolen medications will not be replaced.
- Certain medication regimens will require testing for the presence of resistance-associated viral polymorphisms.
- Prescribers are advised to review FDA approved labeling and other available clinical resources when determining appropriate regimens based on contraindications and warnings – including clinically relevant drug-drug and drug-disease interactions as well as considerations for HIV/HCV co-infected individuals to ensure appropriate monitoring schema are taken into consideration.
- References to ribavirin in this document refer to weight-based ribavirin.
- The following patients should be counseled regarding the 6 month fetal toxicity risk associated with ribavirin use: males if sexually active with a female of childbearing potential, and females of child bearing potential, even after a negative pregnancy test result.
- Certain approvals will be contingent on the use of ribavirin with the approved DAA. If ribavirin is not used as part of the regimen indicated, Alaska Medicaid reserves the right to not extend treatment duration beyond the duration initially authorized.

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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)**

<input type="checkbox"/> Unknown	<input type="checkbox"/> F2
<input type="checkbox"/> F0	<input type="checkbox"/> F3
<input type="checkbox"/> F1	<input type="checkbox"/> 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:

<input type="checkbox"/> A
<input type="checkbox"/> B
<input type="checkbox"/> C

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

9. Is patient HIV co-infected? No Yes
 CD4 Count: _____
 HIV Viral Load: _____

10. 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.

11. Is a recent (within 90 days) urine or blood test for illicit drugs and alcohol **attached**? Yes No

a. If positive results are present but are attributable to legally prescribed medications, please attach the documentation and explain the rationale for the positive results.	<input type="checkbox"/> Positive; attending treatment program <input type="checkbox"/> Positive; referred to treatment program <input type="checkbox"/> Positive; not attending/referred to treatment program
b. If positive results are present but cannot be attributed to legally prescribed medications, please indicate whether the patient is actively attending or has been referred to a treatment program for substance abuse. This applies for any positive test results for alcohol, illicit substances, or prescription drugs for which the patient does not have a prescription. Attach documentation.	

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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"/> 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

Requested Regimen				
Requested Regimen	Regimen	Used in combination with	Duration	Restricted to Specialist
<input type="checkbox"/>	Daklinza + Sovaldi	<input type="checkbox"/> Ribavirin <input type="checkbox"/> Other: _____ <input type="checkbox"/> DAA only	<input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> 16 weeks <input type="checkbox"/> 24 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"/>	Harvoni			
<input type="checkbox"/>	Sovaldi			
<input type="checkbox"/>	Technivie			
<input type="checkbox"/>	Viekira Pak			
<input type="checkbox"/>	Zepatier			
<input type="checkbox"/>	Other:			

Clinical Reason Ribavirin Cannot be Used for Requested Treatment*		
<input type="checkbox"/> Pregnancy <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Hemoglobin < 8.5 g/dL <input type="checkbox"/> Platelet count <75,000 cells/mL	<input type="checkbox"/> Hemoglobinopathy (e.g. sickle cell disease, thalassemia major) <input type="checkbox"/> Documented previous severe ribavirin hypersensitivity reaction	<input type="checkbox"/> History of significant or unstable cardiac disease <input type="checkbox"/> Current use of antiretroviral with clinically significant ribavirin interaction <input type="checkbox"/> Creatinine Clearance < 50 mL/min

*Documentation and an explanation regarding the clinical reason ribavirin cannot be used MUST be attached if any box is selected. Ribavirin use is required unless the patient has one of the above situations, or the FDA-approved DAA regimen being requested for the patient's genotype and disease severity does not include ribavirin.

Required Resistance-Associated Polymorphism Testing				
Previous Treatment Status	Requested Medication	Genotype	Testing Required	Polymorphism Test Results
<input type="checkbox"/> Treatment Naïve OR <input type="checkbox"/> Prior Peg-IFN Treatment	<input type="checkbox"/> Daklinza	<input type="checkbox"/> 1a or 3	<input type="checkbox"/> NS5A	
	<input type="checkbox"/> Zepatier	<input type="checkbox"/> 1a	<input type="checkbox"/> NS5A	
<input type="checkbox"/> DAA Treatment Experienced^	All Medications	All Genotypes		

^Previous treatment with Daklinza, Harvoni, Incivek, Sovaldi, Technivie, Viekira, Victrelis or Zepatier, for example

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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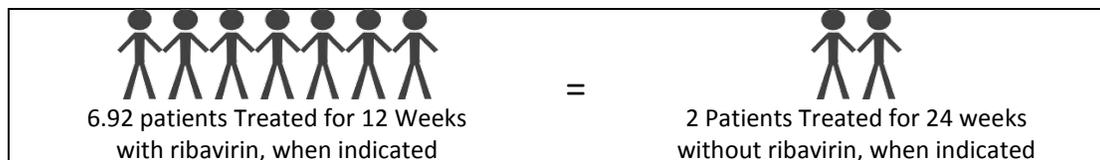
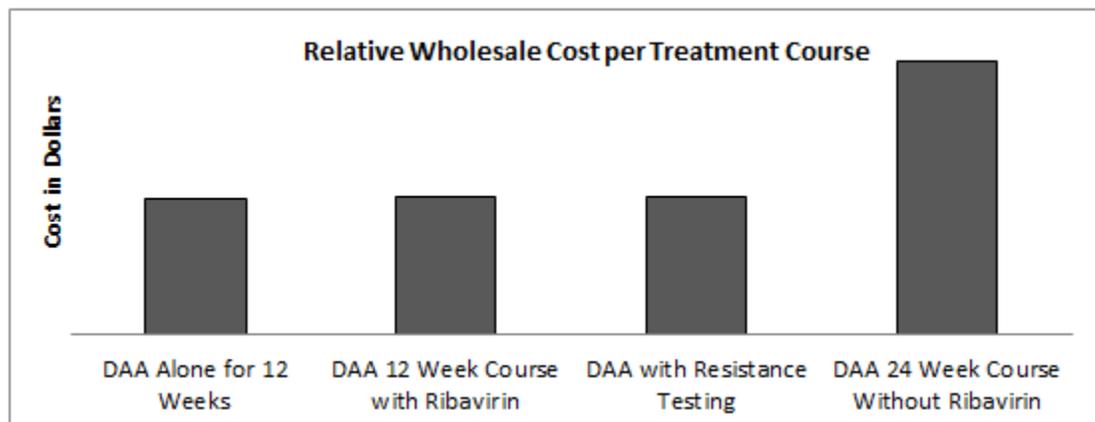
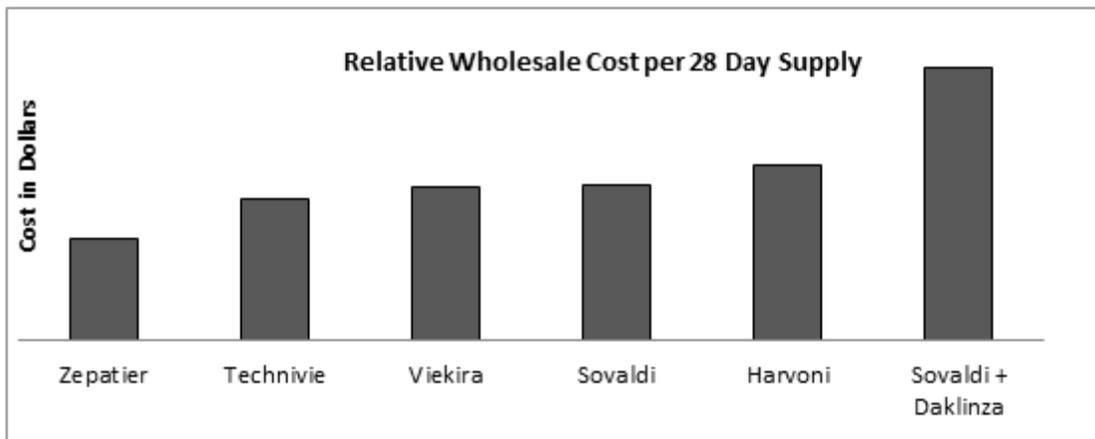
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Last Name:	ID Number:
Please note any other information pertinent to this PA request including unique circumstances that should be considered:	
<div style="font-size: 2em; color: blue; margin-bottom: 10px;">➔</div> <div style="font-size: 2em; color: blue;">➔</div>	<p style="color: blue; text-decoration: underline;">I attest that HCV RNA levels will be obtained and maintained for patient at 12-weeks and 24-weeks post-therapy completion and shall be provided upon request.</p>
<p style="text-align: center;">Direct Prescriber Signature (Required)</p>	<p style="text-align: center;">Date</p>

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



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