

Alaska Medicaid Prior Authorization Form Hepatitis C Direct Acting Antivirals – New Starts

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. 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:

Criteria for Approval (<http://dhss.alaska.gov/dhcs/Pages/pharmacy/medpriorauthoriz.aspx>)

- Patient is at least 18 years old
- Must be prescribed and requested by a provider with an Alaska Medicaid Provider ID
- Documentation must be attached demonstrating that patient meets the diagnosis and disease severity (Metavir fibrosis score of F2-F4 equivalent).
- Hepatitis C, Genotype 1, 2, 3, or 4.
- Usage conforms to FDA package labeling and State of Alaska Medicaid Prior Authorization criteria

Criteria for Denial

- Patient is not abstaining from the use of illicit drugs or alcohol as evidenced by submitted urine confirmation test results.
- Diagnostic/disease severity evidence is not submitted with the request.
- HCV RNA results not submitted with the request.
- For regimens containing ribavirin, patient is pregnant or lactating.
- For regimens containing simeprevir, patient is not simeprevir naïve.
- For regimens containing sofosbuvir, patient has severe renal impairment (eGFR < 30 mL/min/1.73m²) or end stage renal disease (ESRD) requiring hemodialysis.
- Patient has a Child-Pugh score greater than 6 [class B or C] and treatment is not being managed by a liver disease specialist.
- Patient taking concomitant medication that has a significant clinical interaction or is contraindicated with any of the agents.

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

2. Is the requesting physician an Alaska Medicaid provider?

Yes

No

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Clinical Criteria Documentation

3. Has the patient had <u>prior</u> treatment for Chronic Hepatitis C? a. If yes, please list regimen and dates below:	<input type="checkbox"/> Yes	<input type="checkbox"/> No									
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 35%; padding: 5px;">Prior Hepatitis C Regimen(s)</th> <th style="width: 20%; padding: 5px;">Inclusive Dates</th> <th style="width: 45%; padding: 5px;">If discontinued early, please state reason:</th> </tr> </thead> <tbody> <tr> <td style="height: 30px;"></td> <td></td> <td></td> </tr> <tr> <td style="height: 30px;"></td> <td></td> <td></td> </tr> </tbody> </table>	Prior Hepatitis C Regimen(s)	Inclusive Dates	If discontinued early, please state reason:							<i>Prior Regimen Completed?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
Prior Hepatitis C Regimen(s)	Inclusive Dates	If discontinued early, please state reason:									
4. Metavir Fibrosis Score, equivalent (attach documentation)	<input type="checkbox"/> F2 <input type="checkbox"/> F3 <input type="checkbox"/> F4	<input type="checkbox"/> unknown <input type="checkbox"/> F0 <input type="checkbox"/> F1									
5. Baseline HCV Viral Load (attach documentation)	Date: _____										
6. Child-Pugh Score:											
7. Current (within previous 90 days) Renal function (creatinine clearance, estimated):	mL/min <input type="checkbox"/> Normal <input type="checkbox"/> Impaired <input type="checkbox"/> ESRD										
8. Is patient HIV co-infected?	<input type="checkbox"/> Yes	<input type="checkbox"/> No									
	CD4 count _____ Viral load _____										
9. Is a current list of all of the patient's medications attached? (attach documentation) The list should include all scheduled maintenance and as needed medications the patient will be taking while on HCV therapy.	<input type="checkbox"/> Yes	<input type="checkbox"/> No									
10. Is a recent (within previous 90 days) negative urine confirmation attached which demonstrates that the patient has been abstaining from the use of illicit drugs and alcohol? a. If positive results are present, please attach the documentation and explain below:	<input type="checkbox"/> Yes	<input type="checkbox"/> No									

For PATIENTS with GENOTYPE 1

Please select first-line regimen below

Requested Regimen	Genotype/Disease Severity	Regimen	Authorization Length Initial + [Renewal]	Duration	Child-Pugh
<input type="checkbox"/>	GT1a without cirrhosis	Viekira Pak + ribavirin	8 weeks + [4 weeks]	12 weeks	<input type="checkbox"/> A
<input type="checkbox"/>	GT1a with cirrhosis	Viekira Pak + ribavirin	8 weeks + [8 + 8 weeks]	24 weeks	<input type="checkbox"/> A
<input type="checkbox"/>	GT1b without cirrhosis	Viekira Pak	8 weeks + [4 weeks]	12 weeks	<input type="checkbox"/> A
<input type="checkbox"/>	GT1b with cirrhosis	Viekira Pak + ribavirin	8 weeks + [4 weeks]	12 weeks	<input type="checkbox"/> A
<input type="checkbox"/>	GT1, s/p liver transplant	Viekira Pak + ribavirin	8 weeks + [8 + 8 weeks]	24 weeks	<input type="checkbox"/> A

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For PATIENTS with GENOTYPE 1 with documented exclusions to first-line therapy

If the patient has **documented** exclusions to first line therapy, approval may be considered for second line therapy.

<input type="checkbox"/> Yes <input type="checkbox"/> No	Documented Exclusions to 1 st Line therapy (documentation must be submitted with request)	<input type="checkbox"/> Child-Pugh B, C; hepatic decompensation <input type="checkbox"/> Pregnancy <input type="checkbox"/> ESRD <input type="checkbox"/> Hepatocellular Carcinoma (HCC) <input type="checkbox"/> Other Contraindication: _____
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<i>If 'Yes' to Documented Exclusions above, please enter alternate Regimen Requested:</i>	Duration <input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks <input type="checkbox"/> ___ weeks	Child-Pugh <input type="checkbox"/> A <input type="checkbox"/> B* <input type="checkbox"/> C*	Note: <i>Regimens will be approved for no more than 8 weeks at a time. Prescribers must submit Week 4 HCV RNA results for renewal authorization beyond 8 weeks</i>
*Prescriber Specialty:	<input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Hepatologist <input type="checkbox"/> Infectious Disease Specialist <input type="checkbox"/> Other _____		

For PATIENTS with GENOTYPE 2, 3, or 4

Please select regimen:

Requested Regimen	Genotype/Disease Severity	Regimen	Child-Pugh	Duration
<input type="checkbox"/>	GT2 with/without cirrhosis	Sovaldi + ribavirin	<input type="checkbox"/> A <input type="checkbox"/> B* <input type="checkbox"/> C*	12 weeks
<input type="checkbox"/>	GT3 with/without cirrhosis	Sovaldi + ribavirin	<input type="checkbox"/> A <input type="checkbox"/> B* <input type="checkbox"/> C*	24 weeks
<input type="checkbox"/>	GT4 with/without cirrhosis	Sovaldi + peginterferon alfa + ribavirin	<input type="checkbox"/> A <input type="checkbox"/> B* <input type="checkbox"/> C*	12 weeks
<input type="checkbox"/>	GT2, 3, or 4 with HCC	Sovaldi + ribavirin	<input type="checkbox"/> A <input type="checkbox"/> B* <input type="checkbox"/> C*	48 weeks <i>or until liver transplant</i>
*Prescriber Specialty:	<input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Hepatologist <input type="checkbox"/> Infectious Disease Specialist <input type="checkbox"/> Other _____			

For PATIENTS with HEPATOCELLULAR CARCINOMA AWAITING TRANSPLANT

Documentation is attached showing patient meets Milan criteria defined as:

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

Direct Prescriber Signature (Required)

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

Date

Additional Information:

- Use of the Hepatitis C Direct Acting Antiviral Prior Authorization form is not required when submitting an authorization request for a Direct Acting Antiviral; however, its use is encouraged to expedite the submittal and review process.
- Authorizations will not be approved for more than 8 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.
- Renewal authorizations will require results from an HCV RNA titer at treatment week 4 (if regimen 12 weeks or longer) and 8 weeks (if regimen longer than 12 weeks).
- Renewal authorization forms are available at <http://dhss.alaska.gov/dhcs/Pages/pharmacy/medpriorauthoriz.aspx>.
- Claims will not be approved for more than a 28 day supply.
- Daily quantity limits are as follows:
 - VieKira Dose Pak – Four tablets per day (112 tablets/28 days)
 - Harvoni – One 400 mg/90 mg tablet per day (28 tablets/28 days)
 - Olysio – One 150 mg tablet per day (28 tablets/28 days)
 - Sovaldi – One 400 mg tablet per day (28 tablets/28 days)
- References to ribavirin in this document refer to weight-based ribavirin.
- Lost or stolen medications will not be replaced.
- Prescribers are advised to review the full Prior Authorization criteria located at <http://dhss.alaska.gov/dhcs/Pages/pharmacy/medpriorauthoriz.aspx> prior to submitting an approval request.

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