

**NEBRASKA MEDICAID PROGRAM REQUEST FOR PRIOR AUTHORIZATION OF PAYMENT
HEPATITIS C**

PRESCRIBING PROVIDER:

Name: _____
 First Last

Phone #: (____)-_____

Fax #: (____)-_____

NPI # _____

MEDICAID RECIPIENT:

Name: _____
 First Last

Medicaid #:

Date of Birth: //

PARTICIPATING PHARMACY:

Name: _____

Request Date: _____

Phone #: (____)-_____

Fax #: (____)-_____

Please indicate which medications are being requested and complete the information below:

<input type="checkbox"/> Epclusa®	<input type="checkbox"/> Harvoni®	<input type="checkbox"/> Pegasys® _____ (strength)
<input type="checkbox"/> Mavyret®	<input type="checkbox"/> sofosbuvir/velpatasvir (Epclusa AG)	<input type="checkbox"/> Peg-Intron® _____ (strength)
<input type="checkbox"/> Sovaldi®	<input type="checkbox"/> Viekira Pak®	<input type="checkbox"/> Ribavirin capsules or tablets
<input type="checkbox"/> Vosevi™	<input type="checkbox"/> Zepatier™	<input type="checkbox"/> Other:

Indicate reason for request: Acute Hepatitis C ☐ Chronic Hepatitis C ☐ Other ☐ Define other: _____

This request is for: TREATMENT NAÏVE ☐
TREATMENT_EXPERIENCED ☐ PREVIOUS FAILURE OF Direct Acting Antiviral ☐

1. What is the patient's Hepatitis C genotype?
(Submit documentation of completed lab results.)

- ☐ Genotype 1a
☐ Genotype 1b
☐ Genotype 2
☐ Genotype 3
☐ Genotype 4
☐ Genotype 5
☐ Genotype 6

2. What is the baseline quantitative HCV RNA viral load test results: _____
Date measured _____
(Attach a copy of completed lab results within the past year.)

- ☐ Yes
☐ No, Denied pending labs

Prescriber agrees to obtain and submit HCV RNA viral load levels 12 weeks after
completion of treatment.

- ☐ Yes
☐ No, Denied

3. What is the stage of liver disease: _____
(Metavir classification or Child-Pugh score)

4. What is the patient's status of cirrhosis?	<input type="checkbox"/> None <input type="checkbox"/> Compensated <input type="checkbox"/> Decompensated
5. Has the patient been assessed for psychosocial treatment readiness using domains of readiness, including: the client's motivation, information, medication adherence, self-efficacy, social support and stability, alcohol and substance use, psychiatric stability, energy level, and cognitive functioning by a healthcare provider educated on Hepatitis C and signs of readiness? Free online tool, Prep-C, is available to the public (https://prepc.org).	<input type="checkbox"/> Yes, Prep-C <input type="checkbox"/> Yes, other <input type="checkbox"/> No
6. Does the patient have a history of any of the following physical or mental conditions besides Hep C? Mark any that apply and supply any explanation needed: <input type="checkbox"/> Anemia <input type="checkbox"/> Thrombocytopenia <input type="checkbox"/> Chronic Kidney Disease (Stage 3 – Stage 5D) <input type="checkbox"/> Unstable CVD <input type="checkbox"/> Autoimmune disease <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Kidney or other organ transplant <input type="checkbox"/> Untreated hyperthyroidism <input type="checkbox"/> Decompensated Cirrhosis <input type="checkbox"/> Pregnancy (ribavirin causes significant teratogenic effects for as long as 6 months after completion of therapy per black box warning) <input type="checkbox"/> DSM-5 diagnosis of substance use disorder using ASAM criteria and the standardized model of assessment, including those associated with IV drug use, intranasal drug use, and alcohol use (circle) <input type="checkbox"/> DSM-5 diagnosis of depression, irritability, suicidal ideation (circle) <input type="checkbox"/> Other DSM-5 behavioral health diagnoses, including bipolar disorder, mood swings, mania, or schizophrenia (circle) <input type="checkbox"/> Other condition(s) which may affect treatment readiness and/or treatment adherence, Explain →	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain:
7. If additional condition exists, is it controlled: has the patient been compliant with pharmacologic treatment and/or medically appropriate treatment of their diagnosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. If applicable, has the patient been abstinent from drugs/alcohol for at least 6 months? (Pharmacological treatment does not apply here). Please submit standard drug urine screen dated within 15 days of prior authorization request.	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Has a Treatment and Prevention of Re-infection Plan been written with the client's participation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Has patient received prior treatment for Hepatitis C? (A profile review will be performed for verification.) Prior treatment agents:	<input type="checkbox"/> Yes (If yes, please list) <input type="checkbox"/> No
11. Requests for all direct-acting antivirals include evidence of testing for current or prior hepatitis B virus (HBV) infection before initiating treatment. (Please attach results)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Prescriber Signature: _____ **Date:** _____
(With this signature, the prescriber confirms that the information above is accurate and verifiable in patient records.)
Please note: The Department may request chart documentation to verify the above information.

Submit requests to: Magellan Medicaid Administration, Inc. **Fax: 1-866-759-4115**
Tel: 1-800-241-8335