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NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services
Nebraska Medicaid Fee-For-Service Pharmacy Benefit

Magellan Medicaid Administration

Prior Authorization – Hepatitis C Treatment

Fax this form to 1-866-759-4115

Medication regimens*: Epclusa®, Harvoni®, Mavyret®, Peg-Intron®, Pegasys®, Ribavirin, sofosbuvir/velpatasvir (Epclusa AG), Sovaldi®, Viekira Pak®, Vosevi™, Zepatier™.

If the prior authorization (PA) request is approved, payment is still subject to all general requirements including current member eligibility, other insurance, and other program restrictions. If the following information is not complete, correct, or legible, the PA process can be delayed. Use one form per member please.

SECTION 1: MEMBER INFORMATION

Member Last Name: _____

Member First Name: _____ Middle Initial: _____

Member Medicaid ID: _____ Date of Birth: _____

SECTION 2: PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____ Middle Initial: _____

Prescriber NPI: _____ NE Medicaid Provider ID: _____

Prescriber Street Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Prescriber Phone: _____ Prescriber Fax: _____

SECTION 3: MEDICATION REGIMEN REQUESTED

(Please see PDL for preferred status*: Nebraska Medicaid program.)

Medication Regimens (Choose one): Epclusa, Harvoni, Mavyret, Peg-Intron, Pegasys, Ribavirin, sofosbuvir/velpatasvir, Sovaldi, Viekira Pak, Vosevi, Zepatier, Other (specify).

Drug Name: _____ Drug Strength: _____

Dose: _____ Duration of Treatment: _____

Note: The department may request chart documentation to verify all information.

SECTION 4: DISPENSING PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy NPI: _____ NE Medicaid Provider ID: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

Member Name (Last, First): _____

SECTION 5: CRITERIA

Indicate reason for request:

☐ Acute Hepatitis C ☐ Chronic Hepatitis C

☐ Other Define Other: _____

Member treatment status:

☐ Treatment naïve ☐ Treatment Experienced

☐ Previous Failure of Direct-acting anti-viral treatment

Complete all the following information:

1. What is the member's Hepatitis C genotype? (Select one.) (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: _____

   ☐ None, Denied (Attach a copy of completed lab results within the past year.)

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

   ☐ Yes ☐ No, Denied

3. Stage of cirrhosis:

   ☐ None ☐ Compensated ☐ Decompensated

4. Does the member have a history of any of the following conditions? Select any that apply and add an explanation.

   ☐ Anemia ☐ Thrombocytopenia ☐ Chronic Kidney Disease (Stage 3 – Stage 5D)

   ☐ Unstable CVD ☐ Autoimmune disease ☐ HIV/AIDS

   ☐ Kidney or other organ transplant ☐ Untreated hyperthyroidism

   ☐ Decompensated Cirrhosis ☐ Pregnancy (teratogenic effects per boxed warning)

   ☐ DSM-5 diagnosis of substance use disorder using ASAM criteria and the standardized model of assessment, including those associated with IV or intranasal drug use, opioid and alcohol use

   ☐ Other DSM-5 behavioral health diagnoses including but not limited to: depression, irritability, suicidal ideation, bipolar disorder, mood swings, mania, or schizophrenia:

   _____

   ☐ Other condition(s) which may affect treatment readiness and/or treatment adherence:

   _____

   Explanation:

Member Name (Last, First): _____

CRITERIA (CONTINUED)

5. a. If an additional condition exists, is it controlled?

   ☐ Yes ☐ No

   b. Has the member been compliant with pharmacologic treatment and/or medically appropriate treatment of their diagnosis?

   ☐ Yes ☐ No

6. Has the provider submitted **all** the following?
   - Documentation of counseling provided to the member on the harms of alcohol and/or substance use behaviors on treatment.
   - Documentation of counseling encouraging the member to abstain from alcohol before initiation of and during antiviral treatment.
   - Documentation of continued support to the member for alcohol and/or substance use counseling services during antiviral treatment.
   - Documentation of member instruction on the prevention of re-infection, methods of decreasing the risks of re-infection, and abstinence from engaging in such activities.

   ☐ Yes ☐ No

7. Has the member received prior treatment for Hepatitis C? (A profile review will be performed for verification.)

   ☐ Yes ☐ No

   (**If Yes**, attach documentation.)

   Prior treatment agents: _____

8. 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.**

9. Other information pertinent to this request:

☐ Attachments

Prescriber Signature: _____ **Date:** _____

(With this signature, the **prescriber** confirms that the information above is accurate and verifiable in member records.)

Fax this form to: 1-866-759-4115

Or mail to: Magellan Medicaid Administration, Inc. MAP Dept.
Attention: NE Senior Pharmacist
4300 Cox Road
Glen Allen, VA 23060 Tel: 1-800-241-8335