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:

☐ Daklinza®	☐ Epclusa®	☐ Harvoni®	☐Pegasys® _____ (strength)
☐ Mavyret®		☐PegIntron® _____ (strength)	☐Ribavirin capsules or tablets
☐ Sovaldi ®			
☐ Vosevi™	☐ Zepatier™	☐ 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. Has a qualitative evaluation been conducted of liver function? Explain evaluation and degree of fibrosis:	☐ Yes ☐ No, Denied pending evaluation summary and labs/liver biopsy
2. 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
3. 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
4. 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).	☐ Yes, Prep-C ☐ Yes, other ☐ No

5.	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: ☐ 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 (ribavirin causes significant teratogenic effects for as long as 6 months after completion of therapy per black box warning) ☐ 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) ☐ DSM-5 diagnosis of depression, irritability, suicidal ideation (circle) ☐ Other DSM-5 behavioral health diagnoses, including bipolar disorder, mood swings, mania, or schizophrenia (circle) ☐ Other condition(s) which may affect treatment readiness and/or treatment adherence, Explain →	☐ Yes ☐ No Explain:
6.	If additional condition exists, is it controlled: has the patient been compliant with pharmacologic treatment and/or medically appropriate treatment of their diagnosis?	☐ Yes ☐ No
7.	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.	☐ Yes ☐ No
8.	Has a Treatment and Prevention of Re-infection Plan been written with the client's participation?	☐ Yes ☐ No
9.	Has patient received prior treatment for Hepatitis C? (A profile review will be performed for verification.) Prior treatment agents:	☐ Yes (If yes, please list) ☐ No
10.	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)	☐ Yes ☐ 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