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®
- Mavyret®
- PegIntron®
- 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  □ Yes, Prep-C  □ Yes, other  □ No}

Rev. July. 2018 Hepatitis C Form
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 →

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.)  
- [ ] 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