Pharmacy Prior Authorization

MERCY CARE DCS CHP (MEDICAID)

Hepatitis C Medications

This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Mercy Care DSC CHP at **1-800-854-7614**. Please contact Mercy Care DCS CHP at **1-833-711-0776** with questions regarding the prior authorization process. Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Prior authorization for hepatitis C treatment requires submission of medical records with the prior authorization request. *Incomplete and/or illegible request forms may result in a denial including those without medical records.*

Requested Treatment Regimen (Check all medications requested):

☐ **Mavyret**	☐ Epclusa	☐ Harvoni
☐ **sofosbuvir-velpatasvir**	☐ Zepatier	☐ ledipasvir-sofosbuvir
☐ Sovaldi	☐ Vosevi	

☐ Other: Please specify_____

Treatment Duration:

☐ 8 weeks ☐12 weeks ☐16 weeks ☐ 24 weeks ☐Other (please specify) _____

Member Information

Member Name: _____ Member ID #: _____

Member Phone #: _____ Member DOB: _____

Prescriber Information

Prescriber's Name: _____ Office Phone: _____

Prescriber's E-mail: _____ Office Fax: _____

Prescriber's NPI: _____ Office Address: _____

Office Contact Name: _____ City/State/ZIP: _____

Criteria for Approval

Decisions are based on AHCCCS Policy which may be found at:
AHCCCS FFS criteria

Please answer all required questions below and provide relevant supporting information including medical records

1.	**Does the member meet ALL the following treatment requirements?** a) Is the age of the member Food and Drug Administration (FDA) approved for the specific HCV DAA product b) Diagnosis of Hepatitis C infection confirmed by detectable serum HCV RNA quantitative assay within last 90 days, HCV genotype, viral resistance status (when applicable), hepatic status (Child-Pugh Score), and HCV viral load c) Member has been screened for Hepatitis A and B and shall have received at least one Hepatitis A and at least one Hepatitis B vaccine prior to requesting treatment unless the member demonstrated laboratory evidence of immunity.	☐Yes ☐No

	d) **Retreatment Requests only:** Member was adherent to previous DAA therapy as evidenced by medical records and/or pharmacy prescription claims. If prior therapy was discontinued due to adverse effects from DAA, medical records must be provided which documents these adverse effects, and recommendation of discontinuation by treatment provider	
2.	**Is treatment prescribed by, or in consultation with gastroenterologist, hepatologist, infectious disease physician, or HIV specialist certified through the American Academy of HIV medicine?**	☐ Yes ☐No
3.	**Does the member have ANY of the following treatment exclusions?** a) Life expectancy is less than 12 months and cannot be remediated by treating HCV infection, by transplantation, or by other directed therapy b) Member was non-adherent to initial DAA treatment regimen as evidenced by medical records and/or pharmacy prescription claims c) Is considered an experimental service as specified in A.A.C. R9-22-203 d) Member declines to participate in a treatment adherence program e) Member declines to participate in a substance abuse disorder treatment program f) Substance abuse activity within 3 months from date of request for HCV treatment g) Current use of potent P-gp inducer (St. John's wart, rifampin, carbamazepine, ritonavir, tipranavir, etc.) h) Retreatment request is for more than one retreatment with a DAA, and requested retreatment regimen includes more than one DAA i) Direct acting antiviral dosages greater than FDA-approved maximum dosage j) Coverage is for greater than duration of treatment outlined in tables within guideline. k) Lost or stolen medication, or fraudulent use. l) Request for Viekira Pak, Mavyret, and Zepatier in members with Child-Pugh B or C m) Requests for Zepatier, if NS5A polymorphism testing has not been completed and submitted with prior authorization request n) Sovaldi used as monotherapy o) Use in combination with other direct-acting antivirals (DAAs) unless indicated p) Member has contraindication to any of the agents	☐Yes ☐No

The member's treatment status (circle one):

☐Treatment Naïve ☐Treatment Experienced ☐ Status Post Transplant

Prior Hepatitis C Treatments (check all applicable):

Incivek ☐ Victrelis ☐ Olysio ☐ peginterferon ☐ ribavirin ☐ Sovaldi ☐ Harvoni ☐

Daklinza ☐ Technivie ☐ Epclusa ☐ Zepatier ☐ Mavyret ☐ Vosevi ☐ ledipasvir-sofosbuvir ☐

Does prescriber agree to submit required documentation? ☐ Yes ☐No

- HCV viral load laboratory results must be submitted to Contractor/PBM at 12- and 24-weeks post therapy completion to demonstrate Sustained Virologic Response (SVR)
- Prescribing provider assessed the member's ability to adhere to the HCV DAA treatment plan and attests the assessment has been documented within the clinical record. For members that would benefit from adherence aids, the treating provider shall refer the patient to a treatment adherence program.
- Member agrees to adhere to the proposed course of treatment, including taking medications as prescribed, attending follow-up appointments, and, if applicable, participating in a treatment adherence program, has been completed and submitted with this request when: 1) Required regimens whereby the FDA requires such testing prior to treatment to ensure clinical

appropriateness, and 2) Deemed medically necessary by the clinical reviewer prior to approval of the requested regimen

- Provider agrees to monitor hemoglobin levels periodically when a member is prescribed ribavirin
- Laboratory results for ALL of the following: A) HCV screen, B) Genotype and current baseline viral load, C) Total bilirubin, D) Albumin, E) International Normalized Ratio, F) Creatinine Clearance or Glomerular Filtration Rate, G) Liver Function Tests, H) Complete Blood Count (CBC).
- Current medication list

Diagnosis / Dosing (all sections required)		
Diagnosis (include ICD9 Code): _____	**Genotype:** 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ (Submit lab results completed within 90 days of prior authorization request) NS5A polymorphism: 28 ☐ 30 ☐ 31☐ 93☐	**Viral Load (HCV-RNA):** (Submit lab results completed within 90 days of prior authorization request) _____

Please circle **Child Pugh Score**(**required**) and submit supporting documentation with request:
Child Pugh Score

☐ **CPT A** ☐ **CPT B** ☐ **CPT C**

Additional Information:

By signing, the prescribing or authorizing clinician is attesting that information on this form is accurate as of this date, and that documentation supporting above information is recorded in member's medical chart. Requests for Hepatitis C medications must be submitted with supporting medical records.

_____ _____

Prescriber (Or Authorized) Signature **Date**