NEBRASKA MEDICAID PROGRAM REQUEST FOR PRIOR AUTHORIZATION OF PAYMENT

HEPATITIS C

PRESCRIBING PHYSICIAN:
Name: _____
First Last

Phone #: (_____)-_____-_____

Fax #: (_____)-_____-_____

PARTICIPATING PHARMACY:
Name: _____

Phone #: (_____)-_____-_____

MEDICAID RECIPIENT:
Name: _____
First Last

Medicaid # 00000000000

Date of Birth: 00/00/0000 NPI #:

Request Date:_____

Fax #: (_____)-_____-_____

Please indicate which medications are being requested and complete the information below: The medications below in **BOLD** are **PREFERRED** medications

□ **Epclusa®** □ **Harvoni®** □ **Technivie™** □ **Viekira Pak™** □ **Viekira XR™** □ **Pegasys®**

□ **PegIntron®** □ **Ribavirin capsules or tablets** ® □ **Mavyret™** □ Olysio® □ Sovaldi® □ Vosevi™

□ Zepatier™ □ Daklinza® □ Other:_____

For current PDL Status visit: https://nebraska.fhsc.com/downloads/PDL/NE PDL.pdf

1. Indicate reason for request: Acute Hepatitis C □ Chronic Hepatitis C □ Other □ Define other:
2. This request is for: TREATMENT NAÏVE □ RELAPSE □ PARTIAL RESPONDER □ NON-RESPONDER □

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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?
   □ Genotype1a
   □ Genotype 1b
   □ Genotype 2
   □ Genotype 3
   □ Genotype 4

3. What is the baseline quantitative HCV RNA viral load test results:_____
   Date measured_____
   □ Yes
   □ No, Denied pending labs

(Attach a copy of completed lab results within the past year.)

Prescriber agrees to obtain and submit HCV RNA viral load levels 4 weeks After initiation of treatment and 12 weeks after completion of treatment.
□ Yes
□ No

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 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:
□ Yes
□ No

□ 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? □ Yes □ No
(Pharmacological treatment does not apply here). Please submit standard drug urine screen dated within 15 days of prior authorization request.

8. Has a Treatment and Prevention of Re-infection Plan been written with the client's participation? □ Yes □ No

9. Has the patient received prior treatment for Hepatitis C? (A profile review will be performed for verification.) □ Yes □ No

10. Is patient eligible for treatment with pegylated interferon? If not, please explain in space provided:_____ □ Yes □ No
_____

Prescriber Signature:_____ Date:_____
(With this signature, the prescriber confirms that the information above is accurate and verifiable in patient records.)

Please note: Nebraska Total Care may request chart documentation to verify the above information.

Submit requests to: Envolve Pharmacy Solutions Fax: 1-866-399-0929 Tel: 1-844-330-7852
Hepatitis C Form Rev 02/2016