Hepatitis C: Nebraska Medicaid Prior Authorization Process and Criteria

Example Brand Name	Generic
Roferon-A®	Interferon Alfa-2a
Pegasys®	Peginterferon Alfa-2a
Intron A®	Interferon Alfa-2b
PEG-Intron®	Peginterferon Alfa-2b
Infergen®	Interferon Alfacon-1
Copegus®	Ribavirin 200 mg capsule
Rebetol®	Ribavirin 200 mg capsule
Ribasphere®	Ribavirin 200 mg capsule
Ribavirin	Ribavirin 200 mg capsule
Victrelis®	Boceprevir
Olysio®	Simeprevir

NOTE:

- All new interferons marketed after the date of this bulletin shall also be subjected to the criteria in this document.
- Interferons will only be authorized for doses up to FDA approved maximum doses.

An educational pamphlet titled "Living with Chronic Hepatitis C," is available from the Centers for Disease Control at no charge. The following is a direct link to the pamphlet:
http://www.cdc.gov/hepatitis/HCV/PDFs/HepCLivingWithChronic.pdf

DUAL THERAPY – PEGINTERFERON, RIBAVIRIN
Upon completing 12 weeks of therapy, a second test of viral load and genotype is required to be submitted to Magellan Medicaid Administration. The assay must be the same as the assay used to determine the patient's baseline (prior to treatment) viral load.

At week 12, a 2 log decrease in viral titer is required to continue treatment. If such a reduction is observed, authorization will be extended for 12 weeks (24 weeks total) for genotypes 2 or 3 or for 36 weeks (48 weeks total) for genotypes 1 or 4. If at week 12 the 2 log decrease reported is a detectable viral titer and genotype is 1 or 4 a 24 week lab will be required. Continued therapy will not be authorized if the 24 week lab results in a detectable viral titer.

TRIPLE THERAPY – PEGINTERFERON, RIBAVIRIN, PROTEASE INHIBITOR – FOR GENOTYPE 1
NULL RESPONDERS: Prescriber must document the patient-specific rationale for retreatment.

VICTRELIS® (BOCEPREVIR) - For patients 18 years of age or older.
Treatment Duration RESPONSE GUIDED THERAPY

	Assessment* (HCV-RNA Results)		Recommendation
	At Treatment Week 8	At Treatment Week 24	
Treatment Naive Patients	**Undetectable**	**Undetectable**	**Complete triple drug regimen at Treatment Week 28.**
	Detectable	**Undetectable**	**1. Continue triple drug regimen and finish through Treatment Week 36, and then** **2. Administer peginterferon and ribavirin and finish through Treatment Week 48.**
Previous Partial Responders or Relapsers	**Undetectable**	**Undetectable**	**Complete triple drug regimen at Treatment Week 36.**
	Detectable	**Undetectable**	**1. Continue triple drug regimen and finish through Treatment Week 36, and then** **2. Administer peginterferon and ribavirin and finish through Treatment Week 48.**
Previous Null Responders	**Detected or Not Detected**	**Not Detected**	**Continue all three medicines and finish through treatment week 48.**
***TREATMENT FUTILITY** If the patient has HCV-RNA results greater than or equal to 100 IU/mL at treatment week12, then discontinue three medicine regimen. If the patient has confirmed, detectable HCV-RNA at treatment week 24, then discontinue three-medicine regimen.			

Prior Authorizations:
Initial Authorization:

Peginterferon and Ribavirin: 16 weeks Further authorizations: up to 12 week increments.
Victrelis: Start authorization 3 weeks after start of Peginterferon and Ribavirin. Duration: 12 weeks.
Further Authorizations: up to 12 week increments.

Treatment Futility Rules: All Patients

HCV-RNA	Action
Week 12: Greater than 100 IU/ml	Discontinue boceprevir, peginterferon and ribavirin
Week 24: If Detectable	Discontinue boceprevir, peginterferon and ribavirin

OLYSIO™(SIMEPREVIR) TRIPLE THERAPY - For patients 18 years of age or older
Treatment of patients with genotype 1 should be initiated with 12 weeks of simeprevir, peginterferon alpha and ribavirin.
Treatment-naïve and prior relapsers should be treated with an additional 12 weeks of peginterferon alpha and ribavirin, for a total of 24 weeks of therapy.
Prior non-responders (including partial and null-responders) should be treated for an additional 36 weeks of peginterferon alpha and ribavirin for a total of 48 weeks of therapy.

Treatment futility
If HCV RNA is greater than or equal to 25 IU/mL at Week 4, Week 12 or Week 24, discontinue simeprevir, peginterferon alpha and ribavirin.

HOW IS AUTHORIZATION REQUESTED?

PRESCRIBER ---

By Faxing Completed Form to Magellan Medicaid Administration, Inc.: The prescriber must request authorization by faxing the patient's diagnosis and the other required information on a DHHS Fax Form

FAX: 1-866-759-4115
(A fax request form is available at nebraska.fhsc.com)

OR

By Providing the Pharmacist with the Needed Information: The prescriber may provide the needed information on a DHHS Fax Form to the pharmacist. The pharmacist will fax the information to Magellan Medicaid Administration.

PHARMACIST ---

The dispensing pharmacist may use medical information provided by the prescriber to request authorization directly from the Magellan Medicaid Administration Clinical Call Center by calling or faxing the patient's diagnosis and the other required information on a DHHS Fax Form. The pharmacy must maintain this written information for the same length of time as the prescription record is required to be maintained by statute or regulation. Electronic storage/imaging shall meet this requirement.

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(A fax request form is available at nebraska.fhsc.com)