Pharmacy Prior Authorization

Illinois (MEDICAID)

Hepatitis C Medications

This fax machine is in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Illinois at **844-802-1412**. Please contact Illinois at **866-329-4701** 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 this request

Incomplete and/or illegible request forms may result in denial including those without medical records

Requested Treatment Regimen (Check all medications requested):

☐ **Mavyret**	☐ Sovaldi	☐ Harvoni
☐ **Sofosbuvir/Velpatasvir (AG)**	☐ Viekira Pak	☐ Zepatier
☐ Vosevi	☐ Epclusa	☐ 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 Illinois Medicaid Prior Authorization Criteria Policy which may be found at: https://www.aetnabetterhealth.com/Illinois-medicaid

Please answer all required questions below **AND** provide relevant supporting information including medical records.

1.	**Does member meet ALL the following treatment requirements?** a) Age is 6 years or older, or weight is greater than or equal to 17 kilograms b) Diagnosis of Chronic Hepatitis C infection confirmed by the following: i. Detectable serum HCV-RNA quantitative assay within the last 90 days a. If newly diagnosed with Hepatitis C infection within past year, two HCV-RNA levels must be taken at least 6 months apart to demonstrate chronic Hepatitis C Virus infection ii. HCV genotype iii. Viral resistance status (when applicable) iv. Hepatic status (Child-Pugh Score) v. HCV viral load c) Member has been screened for Hepatitis B virus within previous year, and Hepatitis B virus status is addressed appropriately by one of the following: i. Hepatitis B virus negative: If not previously vaccinated, vaccination has been initiated, or there is a plan to initiate (if not contraindicated) ii. Hepatitis B virus positive/history of Hepatitis B (HBV) positive: Will place on suppressive therapy, or monitor for reactivations as is appropriate 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 record must be provided documenting the adverse effects and recommendation of discontinuation by treatment provider	☐ Yes ☐ No
2.	**Is treatment prescribed by, or in consultation with gastroenterologist, hepatologist, or infectious disease physician?**	☐ Yes ☐ No
3.	**Does member have ANY of the following treatment exclusions?** a) Lifetime expectancy is less than 12 months, due to non-liver related comorbid conditions b) Member declines to participate in a treatment adherence program c) Member declines to participate in a substance abuse disorder treatment program d) Substance abuse activity within 3 months from date of request for HCV treatment e) History of substance use disorder within the past 12 months, without evidence of remission during the most recent 3 months f) Current use of a potent P-gp inducer (St. John's wart, rifampin, carbamazepine, ritonavir, tipranavir, etc.) g) Direct acting antiviral dosages greater than the FDA-approved maximum dosage h) Coverage is for greater than duration of treatment i) Lost or stolen medication, or fraudulent use	☐ Yes ☐ No

	j) Viekira Pak, Mavyret, and Zepatier in members with Child-Pugh B or C k) Use in combination with other direct-acting antivirals (DAAs) unless indicated l) Member has contraindication to any of the agents	

Member treatment status (circle one):

☐ Treatment Naïve ☐ Treatment Experienced ☐ Status Post Transplant

Prior Hepatitis C Treatments (check all that apply):

Incivek ☐ Victrelis ☐ Olysio ☐ ribavirin ☐ Sovaldi ☐ Harvoni ☐ Viekira Pak☐

Sofosbuvir/Velpatasvir (AG) ☐ Zepatier ☐ Mavyret ☐ Vosevi ☐

Other, ☐ please specify:_____

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

- Monitoring of Hepatitis C virus ribonucleic acid (HCV-RNA) at treatment week 4- and 12-weeks post treatment
- Member is ready for treatment, and understands treatment regimen, and agrees to remain compliant, and adherent during full course of therapy
- Medical necessity of non-preferred agents
- Prescriber counseling regarding risks of alcohol or intravenous drug abuse, and an offer of referral for substance use disorder treatment when history of abuse is present
- Provider agrees to monitor hemoglobin levels periodically if member is prescribed ribavirin

Diagnosis / Dosing (all sections required)

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