West Virginia Medicaid
Drug Prior Authorization Form

http://www.dhhr.wv.gov/bms/Pharmacy/Pages/default.aspx

Hepatitis-C Therapy Prior Authorization Form

Rational Drug Therapy Program
WVU School of Pharmacy
PO Box 9511 HSCN
Morgantown, WV 26506
Fax: 1-800-531-7787
Phone: 1-800-847-3859

Patient Name (Last) | (First) | (M) | WV Medicaid 11 Digit ID# | Date of Birth (MM/DD/YYYY)

Prescriber Name (Last) | (First) | (MI) | Prescriber Specialty

Prescriber Address (Street) | (City) | (State) West Virginia | (Zip)

Prescriber 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

Pharmacy Name (if applicable)

Pharmacy Address (Street) | (City) | (State) West Virginia | (Zip)

Pharmacy 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

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Important Notes: Preauthorization for medical necessity does not guarantee payment.
The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

The Patient's treatment status is: ☐ Treatment Naive ☐ Prior Relapse ☐ Prior Partial Responder ☐ Null Responder

Prior Hep-C Treatments:	
Reason for Failure:	

Documentation being submitted is current, with labwork from within the past 3 months.		☐ Yes ☐ No	
Is the patient 18 years of age or older?	☐ Yes ☐ No	Has the patient been vaccinated against Hepatitis A and Hepatitis B	☐ Yes ☐ No
Is the patient pregnant, or is the male's female partner pregnant?	☐ Yes ☐ No		
Has the patient been counseled on and agreed to comply with all the conditions stipulated on the Hepatitis-C Patient Consent Form? (Signed patient consent form must be submitted with request)		☐ Yes ☐ No	
Is the patient co-infected with HIV?	☐ Yes ☐ No	If yes, is the patient taking any protease inhibitors?	☐ Yes ☐ No
For HIV co-infected patients, if patient is not taking antiretroviral therapy, is the CD4 count greater than 500 cell/mm^3?		☐ Yes ☐ No	
For HIV co-infected patients, if patient is virologically suppressed (e.g., HIV RNA < 200 copies/mL) , is CD4 count greater than 200 cells/mm^3?		☐ Yes ☐ No	
Is the patient on, or expected to be on, any interacting drug therapies (as listed in the manufacturer's package insert)? If so, please provide a complete medication profile and detail the therapeutic plan to address the patient's needs while being treated for Hepatitis-C.		☐ Yes ☐ No	
Does the patient have severe renal impairment (eGFR<30) or end stage renal disease?	☐ Yes ☐ No	eGFR level and date level was obtained are required	

Diagnosis / Dosing

Diagnosis (Include ICD9 Code)	Genotype (must present lab results)	Viral Load (Must present lab results)

Please indicate fibrosis level (**required**) and submit supporting documentation with request:
Approvals will only be granted for levels of F3 or greater

☐ F1 ☐ F3
☐ F2 ☐ F4

Does the patient have cirrhosis? ☐ Yes ☐ No If Yes, please indicate the Child-Pugh Score:

Does the patient have hepatocellular carcinoma meeting Milan criteria (awaiting liver transplantation)? ☐ Yes ☐ No If yes, please provide the potential transplant date:

Please select one of the following Treatment Regimens below (Non-listed regimens will be considered on a case by case basis)

Select	Diagnosis	Approved Treatment Regimen	Regimen Duration
☐	**Genotype 1, Treatment Naive, HVCV RNA <6mil IU/ml without cirrhosis**	**Harvoni**	**8 weeks**
☐	**Genotype 1, Treatment Naive, HVCV RNA >6mil IU/ml *or* patients with compensated cirrhosis**	**Harvoni**	**12 weeks**
☐	**Genotype 1, Treatment experienced without cirrhosis**	**Harvoni**	**12 weeks**
☐	**Genotype 1, Treatment experienced with cirrhosis OR patients with decompensated cirrhosis**	**Harvoni + ribavirin**	**12 weeks**
☐	**Genotype 1, HIV Co-Infection**	**Sovaldi + peginterferon alfa + ribavirin**	**12 weeks**
☐	**Genotype 1, HIV Co-Infection Interferon Ineligible**	**Sovaldi + ribavirin**	**24 weeks**
☐	**Genotype 2**	**Sovaldi + ribavirin**	**12 weeks**
☐	**Genotype 3**	**Sovaldi + peginterferon alfa + ribavirin**	**12 weeks**
☐	**Genotype 3, Interferon Ineligible**	**Sovaldi + ribavirin**	**24 weeks**
☐	**Genotype 4**	**Sovaldi + peginterferon alfa + ribavirin**	**12 weeks**
☐	**Genotype 4, Interferon Ineligible**	**Sovaldi + ribavirin**	**24 weeks**

Documentation supporting Interferon Ineligible regimens must be submitted with request. Please see PA Criteria for requirements.

Definitions of Interferon Ineligible and Treatment Experienced may be found on the BMS website: http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx

Ribavirin (weight-based)

Medication being requested	Current Weight in Kilograms	Directions for use

Peginterferon-alfa

Medication being requested	Strength	Directions for use

Other pertinent information (attach additional pages if needed).

Attestation: Your signature (manually or electronically) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.

☐ Check here for electronic signature

Prescriber Signature

Date: (MM/DD/YYYY)