Arkansas Medicaid Prescription Drug Program
Hepatitis C Virus (HCV) Medication Therapy Request Sheet

Fax completed form and documentation to the CareSource PASSE™ Pharmacy at **1-866-930-0019**.

Date: _____ Standard ___ Urgent ___

If the following information is not complete, correct or legible, the prior authorization (PA) process may be delayed. Please use one form per member. Information contained in this form is Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA).

Preferred: Zepatier® (elbasvir and grazoprevir); velpatasvir and sofosbuvir (generic for Epclusa®); Mavyret® (glecaprevir and pibrentasvir tablet); Ribavirin 200 mg capsule and tablet.

MEMBER INFORMATION

Member Last Name: _____

Member First Name: _____

Member ID: _____ Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Prescriber National Provider Identifier (NPI): _____ Specialty: _____

Prescriber Phone: _____ Prescriber Fax: _____

DRUG INFORMATION

Drug Name: _____ Drug Strength: _____

Drug Form: _____ Quantity: _____ Dosage Frequency: _____

Drug And Length of Therapy:

- ☐ ZEPATIER + RBV x 16 wks.
- ☐ ZEPATIER x 12 wks.
- ☐ ZEPATIER + RBV x 12 wks.
- ☐ ZEPATIER x 12 wks.
- ☐ ZEPATIER + RBV x 12 wks.
- ☐ ZEPATIER x 12 wks.
- ☐ ZEPATIER + RBV x 16 wks.
- ☐ EPCLUSA x 12 wks.
- ☐ EPCLUSA + RBV x 12 wks.
- ☐ MAVYRET x 8 wks.
- ☐ MAVYRET x 8 wks.
- ☐ MAVYRET x 12 wks.

HCV Population (Choose one that applies):

- ☐ GT-1a; CPS-A, TN or TE-PR, + RAV Resistance
- ☐ GT-1a; CPS-A, TN or TE-PR, - RAV Resistance
- ☐ GT-1a; CPS-A, TE-PR+PI, - RAV Resistance
- ☐ GT-1b; CPS-A, TN or TE-PR
- ☐ GT-1b; CPS-A, TE-PR+PI
- ☐ GT-4; CPS-A, TN
- ☐ GT-4; CPS-A, TE-PR
- ☐ Any GT; TN, or TE-PR, or TE-PR+PI, CPS-A
- ☐ Any GT; TN, or TE-PR, or TE-PR+PI, CPS-B or CPS-C
- ☐ GT-1, 2, 3, 4, 5, or 6; TN, CPS-A
- ☐ GT-1, 2, 4, 5, or 6; TE-PRS^3, No Cirrhosis
- ☐ GT-1, 2, 4, 5, or 6; TE-PRS^3, CPS-A

Member Name: _____

☐ MAVYRET x 12 wks.	☐ GT-1; TE-NS3/4A-PI[2], CPS-A
☐ MAVYRET x 16 wks.	☐ GT-1; TE-NS5A[1], CPS-A
☐ MAVYRET x 16 wks.	☐ GT-3; TE-PRS[3], CPS-A

Key:

- **GT** = Genotype
- **TN** = Treatment Naïve
- **TE** = Treatment Experienced
- **TE-PR** = Treatment Experienced with pegylated interferon + ribavirin (PegINF + RBV)
- **TE-PR+PI** = Treatment Experienced with PegINF + RBV + PROTEASE INHIBITOR (boceprevir, simeprevir, or telaprevir)
- **CPS** = Child Pugh Score (can be A, B or C)
- **RAV** = NS5A resistance-associated polymorphisms, either negative (-) or positive (+) for resistance variants.
- **TE-NS5A[1]** = prior regimens containing ledipasvir and sofosbuvir or daclatasvir with PegINF + RBV without prior treatment with NS3/4A
- **TE-NS3/4A[2]** = regimens contained simeprevir and sofosbuvir, or simeprevir, boceprevir, or telaprevir with PegINF + RBV without prior treatment with an NS5A inhibitor
- **TE-PRS[3]** = regimens containing interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A PI or NS5A inhibitor.

Note:

- Adherence with prescribed therapy is a condition for payment of continuation therapy for up to the allowed time frame for each HCV genotype. The member's drug history will be reviewed prior to approval.
- **Supporting documentation must be included with PA request.** Submitting documentation of the required lab tests for the drug PA request does not constitute approval or payment guarantee for any of the lab tests performed.
- If patient is GT-1a, submit lab results from NS5A resistance-associated polymorphism testing. **This information is mandatory for all GT-1a requests.**
- Submit current documentation for all liver function lab test results, such as Platelets, INR, ALT, AST, etc.

Member Name: _____

CRITERIA

1. Diagnosis:

   ☐ Acute Hepatitis C
   ICD-10 Code: _____

   ☐ Chronic Hepatitis C
   ICD-10 Code: _____

   ☐ Other
   Define "Other" and Provide ICD-10 Code: _____

2. This request is for:

   ☐ Treatment Naïve

   ☐ Treatment Experienced

3. If treatment experienced, list all previous drug regimen(s):

   _____

4. This request is for:

   ☐ New Request

   ☐ Continuation Request

5. Does the member have HIV/HCV or HBV/HCV co-infection?

   ☐ Yes ☐ No

   If Yes, select: ☐ HIV/HCV ☐ HBV/HCV

   If Yes, treatment of HIV/HCV co-infected patients requires continued attention to the complex drug interactions that can occur between DAAs and antiretroviral medications.

6. What is the member's HCV genotype (GT)? Select one:

   ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

7. Provide the member's Child-Pugh or Child-Turcotte-Pugh score (CPS-A, B, or C): _____

   Note: Provide labs and chart notes to support CPS-B and CPS-C.

8. Provide the member's Model for End-State Liver Disease (MELD) score: _____

9. Does the member have any extrahepatic disease manifestations caused by HCV?

   ☐ Yes ☐ No

   If Yes, list: _____

Member Name: _____

CRITERIA (CONTINUED)

10. Does the member have a history of any of the following? Please mark all that apply.

- ☐ Anemia
- ☐ Unstable CVD
- ☐ Kidney Transplant
- ☐ Pregnancy
- ☐ Thrombocytopenia
- ☐ Mental Illness (bipolar, mood swings, mania, schizophrenia)
- ☐ Autoimmune Disease
- ☐ Depression, Irritability, Suicidal Ideation
- ☐ Untreated Hyperthyroidism
- ☐ Chronic Kidney Disease (Stage 3 - Stage 5D)

Attachments ☐

Prescriber Signature: _____ **Date:** _____

All PA requests must be from **a hepatologist, gastroenterologist, infectious disease specialist or a prescriber working under the direct supervision of one of these specialties.**

For questions, call Provider Services at **1-833-230-2100**, available Monday through Friday, 8 a.m. to 5 p.m. Central Time (CT).

NOTE: This facsimile and any attached document are confidential and are intended for the use of individual or entity to which it is addressed. If you have received this in error, please notify us by telephone immediately at **1-833-230-2100**.

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