MERCY CARE (MEDICAID)

Hepatitis C Medications

This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Mercy Care at **1-800-854-7614**. Please contact Mercy Care at **1-800-624-3879** 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 the prior authorization request. ***Incomplete and/or illegible request forms may result in a denial including those without medical records.***

Requested Treatment Regimen (Check all medications requested):

☐ Mavyret ☐ Epclusa ☐ Harvoni
☐ Sovaldi ☐ Viekira Pak ☐ Zepatier
☐ Vosevi

☐ Other: Please specify_____

Treatment Duration:
☐ 8 weeks ☐12 weeks ☐16 weeks ☐ 24 weeks ☐Other (please specify) _____

Patient Information

Patient Name: _____ Member ID #: _____

Patient Phone #: _____ Patient 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 Mercy Care Prior Authorization Criteria Policy which may be found at:
Mercy Care Plan Pharmacy Guidelines

Please answer all required questions below and provide relevant supporting information including medical records

1.	**Does the patient meet ALL the following treatment requirements?** a) Age is equal to or greater than 12 years b) Diagnosis of Hepatitis C infection confirmed by detectable serum HCV RNA quantitative assay within last 90 days, HCV genotype, viral resistance status (when applicable), hepatic status (Child-Pugh Score), and HCV viral load c) Member has been screened for Hepatitis A and B, and must have received at least one Hepatitis A, and at least one Hepatitis B vaccine, prior to requesting treatment, unless member demonstrates laboratory evidence of immunity d) **Retreatment Requests only:** Member was adherent to previous DAA therapy as evidenced by medical records and/or pharmacy prescription claims. If prior therapy	☐ Yes ☐ No

	was discontinued due to adverse effects from DAA, medical records must be provided which documents these adverse effects, and recommendation of discontinuation by treatment provider	
2.	**Is treatment prescribed by, or in consultation with gastroenterologist, hepatologist or infectious disease physician?**	☐ Yes ☐ No
3.	**Does the patient have ANY of the following treatment exclusions?** a) Life expectancy is less than 12 months and cannot be remediated by treating HCV infection, by transplantation, or by other directed therapy b) Member was non-adherent to initial DAA treatment regimen as evidenced by medical records and/or pharmacy prescription claims c) Member declines to participate in a treatment adherence program d) Member declines to participate in a substance abuse disorder treatment program e) Substance abuse activity within 3 months from date of request for HCV treatment f) History of substance use disorder within past 12 months, without evidence of remission during most recent 3 months g) Current use of potent P-gp inducer (St. John's wart, rifampin, carbamazepine, ritonavir, tipranavir, etc.) h) Retreatment request is for more than one retreatment with a DAA, and requested retreatment regimen includes more than one DAA i) Direct acting antiviral dosages greater than FDA-approved maximum dosage j) Coverage is for greater than duration of treatment outlined in tables within guideline. k) Lost or stolen medication, or fraudulent use. l) Request for Viekira Pak, Mavyret, and Zepatier in members with Child-Pugh B or C m) Requests for Zepatier, if NS5A polymorphism testing has not been completed and submitted with prior authorization request n) Sovaldi used as monotherapy o) Use in combination with other direct-acting antivirals (DAAs) unless indicated p) Patient has contraindication to any of the agents	☐ Yes ☐ No

The patient's treatment status (circle one):

☐ Treatment Naïve ☐ Treatment Experienced ☐ Status Post Transplant

Prior Hepatitis C Treatments (check all applicable):

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

Daklinza ☐ Technivie ☐ Epclusa ☐ Viekira XR☐ Zepatier ☐ Mavyret ☐ Vosevi ☐

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

- HCV viral load laboratory results must be submitted to Contractor/PBM at 12 and 24 weeks post therapy completion to demonstrate Sustained Virologic Response (SVR)
- Patient readiness has been assessed, and patient attestation of compliance is submitted, and on file in member's medical record (prescribers shall use the CSPMP as a tool to aid in review of compliance)[1]
- Member agrees to complete the regimen and understands the risks of reinfection and other contributors to liver disease and/or damage, through a signed attestation
- Provider agrees to monitor hemoglobin levels periodically if member is prescribed ribavirin

[1] POST TCN/PC Change Added to require a record of the member's agreement to comply with the treatment

Diagnosis / Dosing (all sections required)		
Diagnosis (include ICD9 Code): _____	**Genotype:** 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ (must submit lab results completed within 90 days of prior authorization request) NS5A polymorphism: 28 ☐ 30 ☐ 31☐ 93☐	**Viral Load (HCV-RNA):** (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 patient's medical chart. Requests for Hepatitis C medications must be submitted with supporting medical records.

_____ _____

Prescriber (Or Authorized) Signature **Date**