Kansas Medical Assistance Program	Aetna Better Health of KS	Sunflower	UnitedHealthcare
PA Phone 800-933-6593	PA Pharmacy Phone 855-221-5656	PA Pharmacy Phone 877-397-9526	PA Pharmacy Phone 800-310-6826
PA Pharmacy Fax 800-913-2229	PA Pharmacy Fax 844-807-8453	PA Pharmacy Fax 866-399-0929	PA Pharmacy Fax 866-940-7328

HEPATITIS C AGENTS PRIOR AUTHORIZATION FORM

Complete form in its entirety and fax to the appropriate plan's PA department.
For questions, please call the pharmacy helpdesk specific to the member's plan.

MEMBER INFORMATION		
Name:	Medicaid ID:	
Date of Birth:	Gender:	
PRESCRIBER INFORMATION		
Name:	Medicaid ID:	
NPI:	Phone:	Fax:
Address:	City, State, Zip Code:	

The following medications require Prior Authorization (PA). Medications requiring PA may have to meet clinical **and** Non-Preferred PA criteria before the claim may be considered for payment.

Please provide the required data for the specific drug being requested. Below is a list of links you may find helpful in determining the required information:

- Clinical PA criteria: http://www.kdheks.gov/hcf/pharmacy/pa_criteria.htm
- KS Preferred Drug List (PDL): http://www.kdheks.gov/hcf/pharmacy/download/PDLList.pdf
- Non-Preferred, PA Required PDL criteria: http://www.kdheks.gov/hcf/pharmacy/download/NonPreferred_PA_Criteria_for_PDL_Drugs.pdf
- KS NDC lookup tool: https://www.kmap-state-ks.us/Provider/PRICING/NDCSearch.asp

Note: Any area not filled out will be considered not applicable to this PA & may affect the outcome of this request.

Instructions to complete this form:

1. Complete **the Member/Provider Information** portion above and **Sections I and II** for **ALL** requests
2. Complete **Section III** for **medication-specific safety criteria** if it applies to the medication requested.
3. Complete **Section IV** for **refractory** requests.
4. Complete **Section V** if this request is a **renewal**.
5. Complete **Section VI** if the requested medication is also a **non-preferred medication** on the Kansas Medicaid PDL.
6. Provider - **Sign and date** the form prior to submission.

SECTION I: MEDICATION REQUESTED

Select the appropriate medication(s) for this request:

☐ Daklinza ☐ Epclusa ☐ Harvoni ☐ Mavyret ☐ Olysio ☐ Sovaldi ☐ Technivie ☐ Viekira Pak ☐ Viekira XR ☐ Vosevi ☐ Zepatier

Directions for Use	**Quantity**

Indication/Diagnosis:

Does the patient have a diagnosis of chronic hepatitis C virus (HCV)? ☐ YES ☐ NO

ICD-10: _____

Expected Duration of Treatment:

☐ 8 weeks ☐ 12 weeks ☐ 16 weeks ☐ 24 weeks ☐ 48 weeks

SECTION II: CLINICAL INFORMATION – For ALL Requests

1. Is this a new or renewal request for this medication?
   - ☐ New
   - ☐ Renewal – Proceed to section V.
2. **Is this request for initial, non-refractory or refractory hepatitis C treatment?**
   - ☐ Initial, non-refractory
   - ☐ Refractory
3. **What is the patient's genotype?**
   - ☐ Genotype 1a ☐ Genotype 1b ☐ Genotype 2 ☐ Genotype 3 ☐ Genotype 4 ☐ Genotype 5 ☐ Genotype 6

PATIENT NAME:		MEDICAID ID:	

SECTION II (CONT.): CLINICAL INFORMATION – For ALL Requests

4. **Is the patient treatment-naïve or treatment-experienced?**

   ☐ Treatment-naïve – (no previous treatment for hepatitis C) – **Proceed to question 6**

   ☐ Treatment-experienced – (previously treated for hepatitis C) – **Proceed to question 5**

5. **Please list all medications the patient has previously tried and failed for the treatment of hepatitis C.**

   **Specify medication name, reason for discontinuation (i.e. inadequate response, allergy, contraindication, intolerance, etc.) and dates of previous trial.

Medication Name	Reason for Discontinuation	Dates of Trial

6. **What is the patient's pre-treatment HCV RNA?**

   HCV RNA (IU/L): _____ Date Drawn: _____

7. **Does the patient have a history of illicit intravenous (IV) substance use within the past 3 months?**

   ☐ YES ☐ NO

8. **Is the medication requested being prescribed in combination with ribavirin?** ☐ YES ☐ NO

   A. **If <u>YES</u>: Is the patient a female of reproductive potential?**

      ☐ YES ☐ NO

      i. **If <u>YES</u>: Does the prescriber attest that the female patient had/will have a negative pregnancy test within 30 days prior to initiation of therapy and monthly thereafter until treatment completion?**

         ☐ YES ☐ NO

9. Does the prescriber attest that the patient's drug profile will be reviewed and monitored for potential clinically significant drug interactions with the requested medication prior to therapy initiation and throughout treatment duration?

   ☐ YES ☐ NO

10. Does the prescriber attest that the patient has been/will be tested for evidence of current or prior hepatitis B virus (HBV) infection by measuring hepatitis B surface antigen (HBsAg) and hepatitis B core antibody (anti-HBc) prior to initiation of HCV treatment?

    ☐ YES ☐ NO

11. Does the prescriber attest that the patient has been fully educated on their treatment and the importance of medication adherence and is motivated to be adherent to the full course of treatment?

    ☐ YES ☐ NO

SECTION III: MEDICATION-SPECIFIC SAFETY CRITERIA

Select the requested medication below and complete the medication-specific safety criteria questions that follow. If the medication for this request is not listed below, skip section III.

☐ **EPCLUSA – Does the prescriber attest to the following criteria?** ☐ YES ☐ NO

1. Patient does not have severe renal impairment (eGFR < 30 mL/min/1.73m^2) or currently require hemodialysis.

☐ **HARVONI – Does the prescriber attest to each of the following criteria?** ☐ YES ☐ NO

1. Patient does not have severe renal impairment (eGFR < 30 mL/min/1.73m^2) or currently require hemodialysis.
2. If Harvoni is co-administered with amiodarone, cardiac monitoring will be done if an alternative, viable treatment option is unavailable.

☐ **MAVYRET – Does the prescriber attest to each of the following criteria?** ☐ YES ☐ NO

1. Patient does not have moderate or severe hepatic impairment (Child-Pugh class B or C).
2. Patient is not on a concurrent direct acting hepatitis C agent or ribavirin.

☐ **OLYSIO – Does the prescriber attest to each of the following criteria?** ☐ YES ☐ NO

1. Patient does not have advanced and/or decompensated cirrhosis (moderate or severe hepatic impairment).
2. Patient has a negative test for NS3-Q80K polymorphism if he/she has genotype subtype 1a.

PATIENT NAME:		MEDICAID ID:	

SECTION III (CONT.): MEDICATION-SPECIFIC SAFETY CRITERIA

☐ **SOVALDI – Does the prescriber attest to the following criteria?** ☐ YES ☐ NO

1. If Sovaldi is co-administered with amiodarone, cardiac monitoring will be done if an alternative, viable treatment option is unavailable.

☐ **TECHNIVIE – Does the prescriber attest to the following criteria?** ☐ YES ☐ NO

1. Patient does not have moderate or severe hepatic impairment or cirrhosis (Metavir score of F4 and Child-Pugh class B or C).

☐ **VIEKIRA PAK/XR – Does the prescriber attest to the following criteria?** ☐ YES ☐ NO

1. Patient does not have underlying moderate to severe hepatic impairment (Child-Pugh class B or C).

☐ **VOSEVI – Does the prescriber attest to the following criteria?** ☐ YES ☐ NO

1. Patient does not have severe renal impairment (eGFR < 30 mL/min/1.73m^2) or currently require hemodialysis.

☐ **ZEPATIER – Does the prescriber attest to each of the following criteria?** ☐ YES ☐ NO

1. Patient does not have moderate or severe hepatic impairment (Child-Pugh class B or C).
2. If patient has genotype 1a, he/she will be/has been tested for the presence of virus with NS5A resistance-associated polymorphisms prior to initiation of therapy.

SECTION IV: CLINICAL INFORMATION – FOR REFRACTORY TREATMENT

NOTE:

- Patient must meet all criteria for non-refractory, initial approval **AND** the following criteria below.
- Pharmacy claims data will be reviewed by the managed care organization to confirm adherence was greater than or equal to 90% with the previous direct-acting antiviral treatment regimen.

1. **Does the patient have a documented presence of detectable HCV RNA at/up to 12 weeks after the last treatment of initial therapy was given?**

   ☐ YES ☐ NO

   A. **If <u>YES</u>: Please document results.**
   HCV RNA (IU/L) at/up to 12 weeks following completion of initial treatment: _____
   Date of Treatment Completion: _____ Date HCV/RNA Drawn: _____

   B. **If <u>NO</u>: Documentation of detectable HCV RNA at/up to 12 weeks following completion of initial Hepatitis C treatment is required for consideration of approval.**

SECTION V: RENEWAL

1. **Date of treatment initiation:** _____
2. **How many weeks of treatment has the patient completed?** _____
3. **Does the prescriber attest that the patient has a documented adherence of greater than or equal to 90% for the prescribed hepatitis C treatment regimen?**

   ☐ YES ☐ NO

SECTION VI: NON-PREFERRED MEDICATION

1. **Is the medication requested a non-preferred medication on the Kansas Medicaid preferred drug list (PDL)?** ☐ YES ☐ NO

   A. **If <u>YES</u>: Does the patient have a documented clinical rationale for using the non-preferred medication that is supported by the product labeling as specified in the Hepatitis C Agents clinical criteria?**

   ☐ YES ☐ NO

   Please submit documentation of clinical rationale to support the use of the requested non-preferred medication.

   _____
   _____
   _____

PATIENT NAME:		MEDICAID ID:	

PRESCRIBER SIGNATURE

☐ **I have completed all applicable boxes and attached any required documentation for review, in addition to signing and dating this form.**

_____ _____

Prescriber or authorized signature **Date**

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.