Print Reset

Arkansas Medicaid Prescription Drug Program

Hepatitis C Virus (HCV) Medication Therapy Request Sheet

Fax completed form and required documentation to Arkansas Medicaid Pharmacy Program

Fax this form to 1-800-424-5851 For questions, call 501-683-4120

If the following information is not complete, correct, or legible, the prior authorization (PA) process can be delayed. Please use one form per beneficiary. Information contained in this form is Protected Health Information under HIPAA.

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

BENEFICIARY INFORMATION

Beneficiary Last Name: _____

Beneficiary First Name: _____

Beneficiary Medicaid ID: _____ Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Prescriber NPI: _____ Specialty: _____

Prescriber Phone: _____ Prescriber Fax: _____

DRUG INFORMATION

Drug Name: _____ Drug Strength: _____

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

Beneficiary's Name: _____

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 timeframe for each HCV genotype. The beneficiary's Medicaid 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 Medicaid 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.

CRITERIA

1. Diagnosis:
   - ☐ Acute Hepatitis C
   - ☐ Chronic Hepatitis C
   - ☐ Other Define Other: _____
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

Beneficiary's Name: _____

CRITERIA (CONTINUED)

5. Does patient 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 patient's HCV genotype (GT)? Select one:
   ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

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

9. Does the patient have any extrahepatic disease manifestations caused by HCV?
   ☐ Yes ☐ No

   If Yes, list: _____

10. Does the patient have a history of any of the following? Please mark all that apply.
    ☐ Anemia
    ☐ Mental illness (bipolar, mood swings, mania, schizophrenia)
    ☐ Unstable CVD
    ☐ Autoimmune disease
    ☐ Kidney Transplant
    ☐ Depression, irritability, suicidal ideation
    ☐ Pregnancy
    ☐ Untreated hyperthyroidism
    ☐ Thrombocytopenia
    ☐ 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.**