

Montana Medicaid Prior Authorization Request for Hepatitis C Treatment

Initiation of Treatment Form

Note: Forms completed by the providing pharmacy will not be accepted. Forms must be completed by the prescribing office.

Patient's Name:	Patient's Medicaid ID#:
Patient's DOB:	Patient's Gender:
Provider's Name:	Provider's Specialty: (Infectious Disease/Gastroenterology/Hepatology)- required
Provider's Phone #:	Provider's Fax #:
Today's Date:	
Requested Drug Regimen and Total Treatment Duration: (subject to MT Medicaid Preferred Drug List)	

I. Patient Readiness Criteria (Check boxes indicate patient/provider acknowledgment):

Patient psychosocial readiness is a critical component for Hepatitis C treatment success. It is important that any potential impediments to the effectiveness of treatment have been identified and that a plan for dealing with these impediments has been developed. The patient must be educated that abuse of alcohol may cause further liver damage and that abuse of IV injectable drugs will increase the risk of re-infection of Hepatitis C if the virus is cleared. Given the high cost of Hepatitis C treatment, we want to ensure that both the provider and the patient feel that the patient is committed to effectively start and successfully adhere to treatment. We highly recommend that you use a patient readiness evaluation tool such as PREP-C, a free interactive online tool which can be found at the following website: <https://prepc.org/>.

- Patient must not have a history of alcohol abuse, injectable drug abuse, and/or other controlled-substance abuse for at least 6 months prior to approval of Hepatitis C treatment. Patient involvement in a support group or counseling is highly encouraged for successful abstinence.
- Patient must be compliant with all current medications that are being prescribed for all disease states/conditions to be considered eligible for Hepatitis C treatment approval.
- Patient must have a history of compliance with scheduled appointments/labs preceding approval of Hepatitis C treatment.
- If patient has mental health conditions, patient must be compliant with mental health medications and/or psychotherapy. If patient has mental health conditions that are not currently being treated, then a mental health consult to assess for patient readiness will be required before Hepatitis C treatment can begin.

Patient signature (required): _____ **Date:** _____

Clinical Requirements:

Attach all supporting documentation.

A. Hepatitis C Virus Assessment:

- Hepatitis C Genotype (and subtype if applicable): _____
- Current quantitative HCV RNA results are attached.

B. Liver Assessment:

*Note: Approval is currently limited to F3 or F4 liver fibrosis staging.

1. Liver Fibrosis Stage: F0 F1 F2 F3 F4
2. If F4 (cirrhotic), determine the Child Pugh Grade:

Assessment Parameter	Possible Points			Points Assigned
	1	2	3	
1. Ascites	Absent	Slight	Moderate	
2. Bilirubin, total (mg/dL)	1.0-2.0	2.0-3.0	>3.0	
3. Albumin (g/dL)	>3.5	2.8-3.5	<2.8	
4. Prothrombin Time -Seconds prolonged OR -International normalized ratio (INR)	1.0-4.0 <1.7	4.0-6.0 1.7-2.3	>6.0 >2.3	
5. Encephalopathy Grade 0-no abnormality detected 1-shortened attention span, impaired addition & subtraction skills, mild euphoria/anxiety 2-Lethargy, apathy, disoriented to time, personality change, inappropriate behavior 3-Somnolence, semi-stupor, responsive to stimuli, confused when awake, gross disorientation 4-Coma, little or no response to stimuli, mental state not testable	None	Grade 1-2	Grade 3-4	
Total				

Adapted from: Pugh RN, Murray-Lyon IM, Dawson JL, Pietroni MC, Williams R. Transection of the oesophagus for bleeding oesophageal varices. Br J Surg. 1973 Aug;60(8):646-9. PMID.

Child Pugh Grade (as determined from total points):

- Child Pugh A (Mild; **Compensated cirrhosis** = 5-6)
- Child Pugh B (Moderate; Significant functional compromise; **Decompensated cirrhosis** = 7-9)
- Child Pugh C (Severe; **Decompensated cirrhosis** = 10-15)

3. Does patient have any *severe* extrahepatic manifestations? Yes No

If yes, please describe: _____

C. Patient History:

- Prescribing specialist chart notes are attached (prescriber must continue to monitor patient throughout treatment course).
- List any previously tried Hepatitis C treatments, dates treated, and response:

- List any over-the-counter medications or nutritional/herbal supplements that patient is currently taking:

D. Required Labs (attached):

- CMP
- CBC
- Liver panel (including AST, ALT, direct bilirubin, total bilirubin, and alkaline phosphatase).
- INR

II. Authorization Limitations:

1. Approval will be granted per FDA-approved labeling for each individual drug (dose and duration of treatment).
2. **Initial approval** will be granted for **4 weeks**.
3. Continuation of therapy beyond 4 weeks will require completion of **Hepatitis C Treatment Renewal Form** [For renewal, lab testing/monitoring as recommended per medication package insert may be required depending on requested treatment regimen].

Provider's Signature: _____ **Date:** _____

**Please complete form, attach documentation, and fax to:
Medicaid Drug Prior Authorization Unit at 1-800-294-1350**



3404 Cooney Drive, Helena, MT 59602
Phone 406.443.6002 • Toll Free Phone 1.800.395.7961
Fax 406.513.1928 • Toll Free Fax 1.800.294.1350

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Renewal

Note: Forms completed by the providing pharmacy will not be accepted. Forms must be completed by the prescribing office.

Patient's Name:	Patient's Medicaid ID#:
Patient's DOB:	Patient's Gender:
Provider's Name:	Provider's Specialty:
Provider's Phone #:	Provider's Fax #:
Today's Date:	Date Regimen Started:
Requested Drug Regimen and Total Treatment Duration: (subject to MT Medicaid Preferred Drug List)	

Renewal Requirements:

- Patient must have been **compliant** with previous 4 weeks of therapy as per protocol.
- Attach appropriate lab monitoring results (as recommended per each individual package insert).

Renewal Limitations:

- Medication(s) will be authorized in **4 week increments** until total approved treatment duration is reached.

Provider's Signature: _____ **Date:** _____

Please complete form, attach documentation, and fax to: Medicaid Drug Prior Authorization Unit at 1-800-294-1350