Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health

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Montana Healthcare Programs Prior Authorization Request for Hepatitis C Treatment

Member's Name:	Member's Medicaid ID#:
Member's DOB:	Today's Date:
Provider's Name:	Provider NPI #:
Provider's Phone #:	Provider's Fax #:

ATTESTATIONS

Providers, please attest to the following:

1. I have discussed the medication and treatment plan with the member, including:
   - Necessity of adherence and follow-up
   - Expected outcome and duration of treatment
   - Possible side effects
   - Monitoring requirements
2. I have performed a Psychosocial Readiness Evaluation for this member and have worked with the member to identify and eliminate barriers to successful treatment. Psychosocial readiness evaluations should include, but are not limited to:
   - Assessment of motivation
   - Social support and stability
   - Medication adherence
   - Alcohol and substance use
   - Psychiatric stability
3. I have evaluated the member's treatment regimen for possible drug interactions and have made any necessary adjustments.
4. I will continue to engage with member throughout treatment and follow-up.
5. Quantitative HCV-RNA testing has been performed to document active HCV infection.
6. HCV RNA viral quantification will be drawn 12-weeks post HCV treatment completion (SVR12) to document treatment results.

Provider Signature:_____ **Date:**_____

Members, please attest to understanding of the following:

1. I understand that not taking my medication every day may result in treatment failure.
2. I understand that I must return to my provider 12 weeks after completing treatment for a lab test which will ensure that treatment was successful. If I fail to return to my provider, I will not be eligible for re-treatment.
3. I understand that there are currently no FDA approved re-treatment options for individuals who fail hepatitis C treatment with Mavyret™. If I fail to achieve a cure, I will not be eligible for re-treatment.
4. For members approved for treatment with a Hepatitis C Direct-Acting Antiviral medication other than Mavyret™, I understand I may not be eligible for re-treatment depending on the medication.

Member Signature:_____ **Date:**_____

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Provider to review and complete the following:

Mavyret™ is Montana Healthcare Programs preferred Hepatitis C treatment for most individuals because it is appropriate for all genotypes, most stages of liver disease, and may only require 8 weeks of treatment.

✓	Check if applicable
☐	**Treatment Naive**
☐	**Liver Fibrosis Stage F0, F1, F2, F3, or F4 (cirrhosis-*compensated*).** See Liver Assessment Tool below to calculate compensated vs decompensated status.

If *both* checked, *Mavyret x 8 weeks will be approved* and remainder of form does not need to be completed. If member does not meet both criteria, and/or Mavyret is not appropriate (e.g. drug interactions) please complete section below.

Only complete the following if above criteria *not* met:

1. Treatment experience:
   - ☐ Treatment naive
   - ☐ Treatment experienced (please indicate regimen(s)): _____
2. Liver Fibrosis Stage:
   ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4-Compensated (Child Pugh A) ☐ F4-Decompensated (Child Pugh B or C)
3. HCV Genotype: _____
4. Requested Drug Regimen and Treatment Duration: _____
5. Provide rationale supporting use of alternative non-preferred drug:

   _____

   _____

LIVER ASSESSMENT TOOL:

If **F4** (cirrhotic), determine compensated (Child Pugh A) vs decompensated (B,C):

Assessment Parameter	Possible Points 1	2	3	Points Assigned
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)

Please complete form and fax to: Montana Healthcare Programs Drug Prior Authorization Unit @ (800) 294-1350