



Arkansas Medicaid Prescription Drug Program
Hepatitis C Virus (HCV) Medication Therapy Request Sheet

Fax completed form and required documentation to the CareSource PASSE™ Pharmacy program at:
1-866-930-0019.

If the following information is not complete, correct or legible, the prior authorization (PA) process may be
delayed. Please use one form per beneficiary. Information contained in this form is Protected Health
Information (PHI) under the Health Insurance Portability and Accountability Act (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 National Provider Identifier (NPI): _____ Specialty: _____

Prescriber Phone: _____ Prescriber Fax: _____

DRUG INFORMATION

Drug Name: _____ Drug Strength: _____

Drug Form: _____ Quantity: _____ Dosage 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.

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-PRS3, No Cirrhosis
GT-1, 2, 4, 5, or 6; TE-PRS3, CPS-A

Beneficiary Name: _____

- | | |
|--|--|
| <input type="checkbox"/> MAVYRET x 12 wks. | <input type="checkbox"/> GT-1; TE-NS3/4A-PI ² , CPS-A |
| <input type="checkbox"/> MAVYRET x 16 wks. | <input type="checkbox"/> GT-1; TE-NS5A ¹ , CPS-A |
| <input type="checkbox"/> MAVYRET x 16 wks. | <input type="checkbox"/> GT-3; TE-PRS ³ , CPS-A |

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-NS5A¹** = prior regimens containing ledipasvir and sofosbuvir or daclatasvir with PegINF + RBV without prior treatment with NS3/4A
- **TE-NS3/4A²** = regimens contained simeprevir and sofosbuvir, or simeprevir, boceprevir, or telaprevir with PegINF + RBV without prior treatment with an NS5A inhibitor
- **TE-PRS³** = 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 time frame 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 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.

Beneficiary Name: _____

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
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. If applicable, has the patient been abstinent from IV drug use or alcohol abuse for \geq 6 months?
 Yes No
If No, is patient currently enrolled in a drug rehabilitation program?
 Yes No

Beneficiary Name: _____

CRITERIA (CONTINUED)

11. Does the patient have a history of any of the following? Please mark all that apply.

- | | |
|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Mental Illness (bipolar, mood swings, mania, schizophrenia) |
| <input type="checkbox"/> Unstable CVD | <input type="checkbox"/> Autoimmune Disease |
| <input type="checkbox"/> Kidney Transplant | <input type="checkbox"/> Depression, Irritability, Suicidal Ideation |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Untreated Hyperthyroidism |
| <input type="checkbox"/> Thrombocytopenia | <input type="checkbox"/> 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.

For questions, call Provider Services at **1-833-230-2100**, available Monday through Friday, 8 a.m. to 5 p.m. Central Time (CT).

NOTE: This facsimile and any attached document are confidential and are intended for the use of individual or entity to which it is addressed. If you have received this in error, please notify us by telephone immediately at **1-833-230-2100**.