COLORADO
Department of Health Care Policy & Financing

Hepatitis C Treatment Prior Authorization (PA) Request Form

Fax completed form and supporting documentation to 1-800-424-5881

See the Preferred Drug List (PDL) page 11-14 for full Hepatitis C PA criteria at: https://www.colorado.gov/hcpf/pharmacy-resources.

Member name: _____ DOB: _____ Medicaid ID: _____
Gender: male □ female □ Is the woman of childbearing potential? □ No □ Yes
If yes, have pregnancy test results been documented within 30 days of expected treatment start date, and counseling has been provided regarding pregnancy and breastfeeding? □ No □ Yes
*If patient is less than 18 years, indicate patient weight (for dosing): _____kg or lbs (circle one)

Physician: _____ Phone: _____ Fax: _____ NPI: _____

Prescriber signature (required): _____ Date: _____
Is the prescriber an infectious disease specialist, gastroenterologist, or hepatologist? □ No □ Yes
If no, is the requested drug being prescribed by a primary care provider (PCP) in consultation with an infectious disease specialist, gastroenterologist, or hepatologist (CIRCLE one)? □ No □ Yes
If yes, provide first and last name of consulted specialist: _____
If no, is the requested drug being prescribed for treatment naïve member without cirrhosis, by a PCP who has completed the HCV ECHO series (CIRCLE one)? □ No □ Yes

1- Has member previously received direct acting antivirals (DAAs) or been treated for Hepatitis C?
If yes, fill in Re-treatment box and complete #1-12. If no, fill in Initial treatment box and complete #1-19. □ No □ Yes

Pre-treatment

2- Patient records are attached indicating vaccination status or immunity to Hepatitis A and B? □ No □ Yes
(Due to risk of HBV reactivation with DAAs, health care professionals should screen and monitor for HBV in all patients receiving DAA treatment.)

3- Physician attests to meeting one of the following (check one):
- Member has a diagnosis of chronic HCV infection (presence of HCV RNA viral load for ≥ 6 months) □
- Member has a diagnosis of acute HCV infection in the setting of solid organ transplant □
- Member will be treated upon initial HCV diagnosis (acute infection) and acknowledges that the rate of spontaneous resolution of acute infection has been considered as part of assessing the need to initiate antiviral therapy (acute HCV infection may spontaneously clear in 20-50% of patients) □

4- Provider attests that member is ready to be compliant to the medication regimen □ No □ Yes
- Prescribers should utilize assessment tools to evaluate readiness of the patient for treatment
  - https://www.thenationalcouncil.org/wp-content/uploads/2020/04/Screening-for-Viral-Hepatitis-within-Behavioral-Health-Organizations-7.9.14.pdf?daf=375ateTbd56
  - Psychosocial Readiness Evaluation and Preparation for Hepatitis C Treatment (PREP-C) available at: https://prepc.org/)

5-Member's complete current medication list is attached, AND Provider attests that significant drug-drug interactions have been screened for and/or addressed before and during treatment. □ No □ Yes
May use https://www.hep-druginteractions.org/

6- If the member is abusing/misusing controlled substances and/or alcohol, the provider attests that the member been enrolled in counseling or substance use treatment program. □ No □ Yes
- Treatment referrals can be requested from the member's care coordinator, the Regional Accountable Entity, by calling customer service which is accessible at: https://www.healthfirstcolorado.com/health-first-colorado-regional-organizations /

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7- Required lab tests (taken within past 6 mo) are submitted with this request:

- Quantitative HCV RNA viral load
- Complete Blood Count (CBC)
- Hepatic Function Panel (i.e. albumin, total and direct bilirubin, alanine aminotransferase (ALT), aspartate aminotransferase (AST), and alkaline phosphatase levels)
- Calculated glomerular filtration rate (GFR)
- If cirrhosis is present, calculation of the Child-Turcotte-Pugh (CTP) Score
- Transplant status as applicable (pre-, post-, N/A)

8- Liver fibrosis test is submitted (this is not required, but, if available): □ No □ Yes

Post Treatment:

9-Provider attests to provide one HCV RNA test result from 12-24 weeks post-treatment □ No □ Yes

- Please submit Health First Colorado HCV Treatment Outcomes Form (accessible from the Pharmacy Resources Page)

Initial treatment requests (Fill in requested drug regimen and duration in table below)

Drug	**Strength/ Formulation***	**Duration (weeks)**	**Preferred Initial Treatment Regimens** *(GT-Genotype, NC-No-Cirrhosis, CC-Compensated Cirrhosis, DC-Decompensated Cirrhosis)*
ledipasvir/sofosbuvir (Harvoni)			Members 3 years and older for GT 1, 4-6 with NC or CC; or GT 1 in combination with ribavirin in DC; or GT 1,4 in combination with ribavirin for liver transplant recipients with NC or CC. If request is for pellets, member is 3 years of age or older weighing less than 17kg OR 3 years or older that are unable to take/swallow ledipasvir/sofosbuvir oral tablets
Mavyret	100mg-40mg		Members 12 years and older or weighing at least 45 kg with NC or CC (Child-Pugh A only)
Sofosbuvir/velpatasvir (Epclusa)			Members 6 years and older or weighing at least 17 kg for with NC or CC (Child-Pugh A only); or in combination with ribavirin in DC

Retreatment or prior exposure to DAAs (Fill in requested drug regimen and duration in table below)

Drug	**Strength/ Formulation***	**Duration (weeks)**	**Preferred Regimens For Retreatment or treatment experienced** *(GT-Genotype, NC-No-Cirrhosis, CC-Compensated Cirrhosis, DC-Decompensated Cirrhosis)*
Mavyret	100mg-40mg		Members 12 years and older or weighing at least 45 kg with NC or CC (Child-Pugh A only); or for GT 1, who previously have been treated with a regimen containing an HCV NS5A inhibitor or an NS3/4A protease inhibitor (PI), but not both
Sofosbuvir/velpatasvir (Epclusa)			Members 6 years and older or weighing at least 17 kg with NC or CC (Child-Pugh A only); or in combination with ribavirin in DC
Vosevi	400mg-100mg-100mg		Members 18 years or older with chronic HCV infection with NC or CC (Child-Pugh A only) and either previously failed treatment with a regimen containing an NS5A inhibitor (such as ledipasvir, daclatasvir, or ombitasvir) OR are GT 1a or 3 and previously failed treatment with a regimen containing sofosbuvir without an NS5A inhibitor

10- List previous treatment regimen received, and date received: _____

11- Genotype of first treatment and current genotype (if known) Previous _____ Current _____

12- Was the entire treatment regimen completed? □ No □ Yes If no (early discontinuation occurred), please describe: _____

- Adverse effects experienced from previous treatment regimen
- Concomitant therapies during previous treatment regimen

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3rd page only needs to be attached if applicable to request.

Non-Preferred DAAs
If not prescribing a preferred treatment regimen, provide rationale and supporting documentation (Acceptable rationale may include member has initiated treatment on a non-preferred drug and needs to complete therapy, patient-specific medical contraindications to a preferred treatment).

_____
_____
_____
_____

Ribavirin (Note: Preferred ribavirin products do not require a PA)
Is member ineligible for ribavirin? □ No □ Yes
If so, please provide documentation and medical notes for consideration of approval.

_____

_____

_____

Does the requested regimen include ribavirin? □ No □ Yes
If yes, Provider Attests to the following:

- Member is not a pregnant female or a male with a pregnant female partner
- Women of childbearing potential and their male partners must attest that they will use two forms of effective (non-hormonal) contraception during treatment
- Member does not meet any of the following ineligibility criteria for use of ribavirin:
    - Pregnant women and men whose female partners are pregnant
    - Known hypersensitivity to ribavirin
    - Autoimmune hepatitis
    - Hemoglobinopathies
    - Creatinine Clearance < 50mL/min
    - Co-administered with didanosine