Hepatitis C Therapy Retreatment Form

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

West Virginia Medicaid
Bureau for Medical Services

Rational Drug Therapy Program
WVU School of Pharmacy
PO Box 9511 HSCN
Morgantown, WV 26506
Fax: 1-800-531-7787
Phone: 1-800-847-3859

Patient Name (Last) | (First) | (M) | WV Medicaid 11 Digit ID # | Date of Birth (MM/DD/YYYY)

Prescriber Name (Last) | (First) | (MI)

Prescriber Specialty | MD or DO | NP | PA

Prescriber Address (Street) | (City) | (State) | (Zip)

Prescriber 10-Digit NPI # | Phone # (111-222-3333) | Fax # (111-222-3333)

Important Notes: Preauthorization for medical necessity does not guarantee payment.

Medication Name & Dosage Form | Strength | Directions | Duration

If addition of **ribavirin** is recommended by current Infectious Diseases Society of America (IDSA)/American Association for the Study of Liver Diseases (AASLD) guidelines for this patient's treatment, please utilize the ribavirin section at the end of page 3.

Patient must have a fibrosis score and one detectable Hepatitis C Viral Load with genotype within the past six months (lab results must be attached).

Fibrosis Score | Date Obtained (Attach Results) | Genotype | Date Obtained (Attach Results)

Is the patient co-infected with HIV?	☐ No	☐ Yes*
Is the patient currently pregnant?	☐ No	☐ Yes*
Is the patient concurrently infected with hepatitis B?	☐ No	☐ Yes*
Does the patient have cirrhosis?	☐ No	☐ Yes*
If the patient has cirrhosis, please indicate the Child-Pugh-Turcotte score:	☐ A ☐ B	☐ C
If the patient has cirrhosis, please indicate if the patient's cirrhosis is compensated or decompensated:	☐ Compensated	☐ Decompensated

* (If selecting "Yes" to any of the above questions, a consult with a specialist physician is required. Please complete the section at the end of page 3)

Patient must have received vaccination for hepatitis A and B or have evidence of current immunity (please indicate one of the following):

☐ Patient has been vaccinated against hepatitis A and B (please attach vaccination records)

☐ Patient has evidence of immunity to hepatitis A and B (please attach serology lab results)

Has the patient been educated on and agreed to comply with all the conditions stipulated on the Hepatitis C Patient-Provider Enrollment form? (signed form must be submitted with request)	☐ Yes	☐ No

Previous Treatment Course Details (please attach previous genotype lab and sustained virologic response at 12 weeks (SVR12) lab):

Date Range of Previous Treatment		Previous Medication	Previous Infection Genotype	SVR12 Date	SVR12 Result
	to				

Reason for retreatment:

☐ Treatment Failure ☐ Reinfection ☐ Noncompliance/Incomplete Treatment ☐ Other (explain below)

Retreatment Course Details and Plan:

Was the patient compliant on the previous course (few to no missed doses)? If no, please document the reason(s) for noncompliance. ☐ Yes ☐ No

Describe any factors (in addition to noncompliance) that led to treatment failure/reinfection in this patient.

How have the factors listed above (including noncompliance) been addressed with the patient to prevent repeated treatment failure/reinfection?

Has the patient received education regarding risk behaviors associated with Hepatitis C infection?

Please briefly outline the plan for monitoring for adherence and successful completion of the retreatment course.

Next Follow-Up Appointment:

Date: Setting: ☐ In-Person ☐ Virtual/Telehealth ☐ Phone Call by Staff

Subsequent Follow-Up Appointments:

Frequency: Setting: ☐ In-Person ☐ Virtual/Telehealth ☐ Phone Call by Staff

Additional Comments (attach additional pages if necessary):

Does the prescriber attest that the patient is willing and able to comply with the requirements of the above treatment plan? ☐ Yes ☐ No

Does the prescriber attest that any factors that may have led to noncompliance with the previous treatment(s) have been addressed? ☐ Yes ☐ No

Please ensure your submission contains all required attachments:

- ☐ Hepatitis C Virus (HCV) RNA Quantitative lab results within the last six months
- ☐ HCV Genotype lab results within the last six months
- ☐ HCV Fibrosis Score within the last six months
- ☐ Hepatitis A & B vaccination records or serology results
- ☐ Signed Patient-Provider Enrollment form
- ☐ HCV Genotype lab results from before the previous treatment course
- ☐ SVR12 lab results from after the previous treatment course

Attestation: Your signature (manually or electronically) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.

☐ Check here for electronic signature

Prescriber Signature _____ Date: (MM/DD/YYYY) _____

If the patient is not prescribed Mavyret or Epclusa, OR is younger than 18 years of age, OR is positive for hepatitis B infection, OR is co-infected with HIV, OR is currently pregnant, OR has cirrhosis then the medication must be prescribed by or in consultation with a gastroenterologist physician, a hepatologist physician, or an infectious disease physician.
If the prescriber on this request is not one of the above types of specialist physicians, please provide:

Name of Consulting MD/DO specialist physician: _____

Date of Consult: _____

Type of Consult: ☐ Phone ☐ Electronic Correspondence ☐ In Person ☐ WV Hepatitis Academic Mentoring Partnership (WVHAMP)

If addition of ribavirin is recommended by current IDSA/AASLD guidelines for this patient's treatment, please indicate the dose/directions prescribed or indicate the reason the patient is ribavirin-ineligible.

	Strength	Directions	Duration
☐ Ribavirin prescribed:			

☐ Ribavirin is not recommended by IDSA/AASLD guidelines

☐ Patient is ribavirin-ineligible (select all that apply):

- ☐ History of severe or unstable cardiac disease
- ☐ Pregnant women and men with pregnant partners
- ☐ Hypersensitivity to ribavirin
- ☐ Diagnosis of hemoglobinopathy (e.g. thalassemia major, sickle cell anemia)
- ☐ Baseline platelet count < 70,000 cells/mm^3
- ☐ Absolute neutrophil count (ANC) < 1,500 cells/mm^3
- ☐ Hemoglobin < 12 g/dL in women, or < 13 g/dL in men

Other pertinent information (attach additional pages if needed):