West Virginia Medicaid
Drug Prior Authorization Form

https://dhhr.wv.gov/bms/BMS%20Pharmacy/Pages/PA-Criteria.aspx

Hepatitis-C Therapy Prior Authorization Form

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

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

(State): West Virginia

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

Pharmacy Name (if applicable)

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

(State): West Virginia

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

Important Notes: Preauthorization for medical necessity does not guarantee payment.
The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

The Patient's treatment status is: ☐ Treatment Naive ☐ Prior Relapse ☐ Prior Partial Responder ☐ Null Responder

Prior Hep-C Treatments:	
Reason for Failure:	

Has the patient been vaccinated for Hepatitis A and B? ☐ Yes ☐ No

Is the patient 18 years of age or older? ☐ Yes ☐ No | Is the patient pregnant? ☐ Yes ☐ No

Has the patient been counseled on and agreed to comply with all the conditions stipulated on the Hepatitis-C Patient-Provider Agreement Form? (Signed patient consent form must be submitted with request) ☐ Yes ☐ No

Is the patient co-infected with HIV? ☐ Yes ☐ No | Does the patient have severe renal impairment (eGFR<30) or end stage renal disease? ☐ Yes ☐ No

Please provide eGFR and date obtained (required) | What is patient's current weight?

Is the patient on, or expected to be on, any interacting drug therapies (as listed in the manufacturer's package insert)? If so, please provide a complete medication profile and detail the therapeutic plan to address the patient's needs while being treated for Hepatitis-C. ☐ Yes ☐ No

Diagnosis (Include ICD9 Code)	Genotype (must present lab results)	Indicate Fibrosis Score (F0 to F4)

Two (2) HCV viral load measurements taken at least six months apart (must present lab results)

Viral Load 1 _____ Date Measured: _____

Viral Load 2 _____ Date Measured: _____

Does the patient have cirrhosis? ☐ Yes ☐ No If Yes, please indicate if compensated or decompensated with the Child-Pugh Score: _____

Is the patient awaiting liver transplantation? ☐ Yes ☐ No If yes, please provide the potential transplant date: _____

Please detail the drug regimen requested, including the drug, dose and duration. For your convenience, a list of recommended regimens (by genotype and clinical presentation) may be found on the HEP-C PA Criteria Page.

(Documentation supporting Interferon Ineligible regimens must be submitted with request. Please see PA Criteria for requirements.)

☐ IFN-Ineligible

- ☐ Documented life-threatening side effects or potential side effects (i.e. history of suicidality)
- ☐ Decompensated cirrhosis (Child-Pugh > 6), or Child-Pugh ≥ 6 if HIV co-infected
- ☐ Blood dyscrasias: Baseline neutrophil count <1500/µL, baseline platelets <90,000/µL or baseline Hgb <10g/dL
- ☐ Pre-existing unstable or significant cardiac disease (e.g. history of MI or acute coronary syndrome)

☐ Ribavirin-Ineligible

- ☐ History of severe or unstable cardiac disease
- ☐ Pregnant women and men with pregnant partners
- ☐ Diagnosis of hemoglobinopathy (e.g. thalassemia major, sickle cell anemia)
- ☐ Hypersensitivity to ribavirin
- ☐ Baseline platelet count <70,000 cells/mm3
- ☐ ANC <1,500 cells/mm3
- ☐ Hb <12 gm/dl in women, or <13 gm/dl in men

Patients with CrCl <50 ml/min (moderate or severe renal dysfunction, ESRD, HD) should have dosage reduced.

Other pertinent information (attach additional pages if needed). If consulting, please include the consulting physician's contact info.

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) _____