Acentra HEALTH

Prior Authorization Vendor for ND Medicaid

Hepatitis C Treatments
Prior Authorization Form

Fax completed form to:
855-207-0250
For questions regarding this prior authorization, call
866-773-0695

ND Medicaid requires that members receiving a prescription for hepatitis C treatments to meet specific clinical criteria for coverage which can be found at https://ndmedicaid.acentra.com/ndpdl/. ***No need for chart notes or labs*** *(HCV RNA level, fibrosis, drug/alcohol screens).*

Member Name	Member Date of Birth	Weight (kg)	Member Medicaid ID Number	
Prescriber Name	Telephone Number		Fax Number	
Address	City		State	Zip Code
Prescriber NPI	Diagnosis for the Request		Genotype	
Requested Drug and Directions:	**Duration:**	**Strength:**	**Dosage Form (e.g., tablet):**	

The following questions are used to verify the prescribed regimen is appropriate:

1. Is the member's life expectancy greater than one year? ☐ YES ☐ NO
2. Does the member have compensated cirrhosis (CTP score A)? ☐ YES ☐ NO
3. Does the member have decompensated cirrhosis (CTP score B or C)? ☐ YES ☐ NO
4. Does the member have co-infection with HIV? ☐ YES ☐ NO
5. Does the member have liver transplant? ☐ YES ☐ NO

The following questions are used to verify members are counseled on harm reduction and treatment options who are actively using or recently in recovery from alcohol use disorder or IV illicit substances:

1. Does the member have a history of alcohol use disorder or IV illicit substance use?
   Check "No" for marijuana use or social alcohol use.
   - ☐ YES - *please continue to next question in this section*
   - ☐ NO - *you do not need to complete the remainder of this section*
2. Has the member used alcohol or IV illicit substances in the past year?
   - ☐ YES - *please continue to next question in this section*
   - ☐ NO - *you do not need to complete the remainder of this section*
3. Has the member completed or is member currently enrolled in a treatment program within the last year?
   - ☐ YES - *you do not need to complete the remainder of this section*
   - ☐ NO - *please continue to next question in this section*
4. Has the Harm Reduction Program Participation Attestation (last page of this form) been completed?
   - ☐ YES
   - ☐ NO - *this is a requirement for approval*

The following question is intended to direct completion of the applicable sections of this form and to apply prior authorization criteria:

1. Is this request for **initial** or **re-infection** treatment with a Direct Acting Antiviral, or **incomplete therapy** after receiving **<28 days**? *Please answer "yes" even if member has had previous treatment with interferon and/or ribavirin*
   - ☐ Initial treatment - *Please proceed to Section A.*
   - ☐ Re-infection - *Please proceed to Section A.*
   - ☐ Incomplete therapy after receiving <28 days - *Please proceed to Section A AND Section C.*
   - ☐ No (request is for re-treatment/failed therapy or incomplete therapy after receiving ≥ 28 days) - *Please proceed to Section B. Please also proceed to Section C for incomplete therapy.*

Please continue to next page →

SECTION A: FOR INITIAL, RE-INFECTION, OR INCOMPLETE THERAPY <28 DAYS ONLY

The following questions are used to verify the member's hepatitis C infection is classified as chronic hepatitis C:

1. Does member have known fibrosis or cirrhosis (used to determine # of HCV RNA labs required)?
   If fibrosis/cirrhosis is not known, please check "No" and provide the dates for 2 detectable HCV RNA labs.

☐ YES - one detectable HCV RNA lab is required (must be within last 2 years)

- Date of detectable lab: _____

☐ NO –
two detectable HCV RNA labs are required (must be at least 3 months apart from each other with most recent being within past 2 years) **OR**

one detectable HCV RNA lab is required with the last likely HCV exposure occurring at least 6 months prior to the most recent positive test (must be within last 2 years)

- Date of detectable lab #1 _____
- Date of detectable lab #2_____
- Date of last likely HCV exposure _____

If you are unable to find the date for detectable HCV RNA labs, NDHHS surveillance coordinators can help by accessing the ND HIN or reaching out to other states to check for this lab completion. You can reach them at 701-328-2378.

SECTION B: FOR RE-TREAMENT OR INCOMPLETE THERAPY AFTER RECEIVING ≥ 28 DAYS

1. Did member achieve SVR12 with previous DAA therapy?
   - ☐ YES – *Please complete the initial / re-infection section. Re-treatment section does not apply.*
   - ☐ NO
2. Reason for re-treatment:
   - ☐ Non-compliance with previous regimen (MPR < 80%) – *Please fill out Section C for non-adherence below.*
   - ☐ Resistance
   - ☐ Other _____
3. Specialist involved in therapy (including Project Echo):_____
4. Does member have compensated cirrhosis (CTP score A)? ☐ YES ☐ NO
5. Does member have decompensated cirrhosis (CTP score B or C)? ☐ YES ☐ NO
6. One HCV RNA lab is required since most recent DAA treatment (must be within last 2 years)
   Value _____ Date of HCV RNA lab: _____

SECTION C: FOR PREVIOUS INCOMPLETE THERAPY

1. How many days were missed in the first 28 days of therapy?
   - ☐ ≤ 7 days
   - ☐ ≥ 8 days
2. How many days were missed after the first 28 days of therapy?
   - ☐ ≤ 7 days
   - ☐ 8-20 consecutive days
   - ☐ ≥ 21 consecutive days
3. Has member participated in one visit focusing on addressing adherence barriers in the past 180 days? ☐ YES ☐ NO

Prescriber (or Staff) / Pharmacy Signature**	**Date**

***: By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Harm Reduction Program (Participation Attestation)

For persons who inject drugs:

- ☐ My patient participates in a Syringe Service Program (SSP)

OR

- ☐ My patient has attended at least 2 visits focused on Harm Reduction. *Please fill out the remainder of this section:*
  - ☐ I have evaluated that my patient has implemented the following activities
    - ☐ Use of sterile syringes, needles, and injection equipment
    - ☐ Storage and disposal of injection equipment in a safe and legal manner
  - ☐ My patient has received the following information/education:
    - ☐ Referral to or participation in an SSP
    - ☐ Drug overdose response and treatment; including access to naloxone
    - ☐ Education, referral, and linkage to human immunodeficiency virus, viral hepatitis, and sexually transmitted disease prevention, treatment, and care services
    - ☐ Substance Use Disorder treatment information and referral to Substance Use Disorder treatment programs

For people with Alcohol Use Disorder:

- ☐ My patient has attended at least 2 visits focused on Harm Reduction. *Please fill out the remainder of this section:*
  - ☐ My patient has received the following information/education:
    - ☐ The impact of alcohol to liver health (i.e., continued use can result in development of cirrhosis even in the absence of Hepatitis C)
    - ☐ How to reduce risk and severity of harmful consequences arising from severe alcohol intoxication (e.g., transportation services, condom use, avoiding fighting, drinking low alcohol beverages, padding furniture and stairs)
    - ☐ Safer-use Strategies: Alcohol
    - ☐ Alcohol addiction treatment information and referral to alcohol treatment programs
  - ☐ I have evaluated that my patient has implemented the following activities
    - ☐ Safer-use and risk reduction strategies

MTM pharmacist, prescriber representative or SSP representative:

Signature_____ **Date** __/__/____