Hepatitis C Treatments Prior Authorization Form

Fax Completed Form to: 855-207-0250
For questions regarding this Prior authorization, call 866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that members receiving a prescription for hepatitis C treatments must meet the criteria listed in the preferred drug list (PDL). Please see the PDL at www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf
Please complete this form in its entirety and provide all required documentation (if available)

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dose:	**Duration requested:**	**Member's liver fibrosis score:** ☐ F0-F1 ☐ F2-F4
Diagnosis: ☐ HCV ☐ OTHER:	**Genotype:**	**Member's Child–Pugh Class:** ☐ A ☐ B ☐ C ☐ N/A

Please list any previous treatments the member has failed for chronic HCV: ☐ N/A	Regimen:	Dates of treatment:	Response:

Has the member remained drug (illicit use by injection) and alcohol free for the past 3 months?	☐ YES ☐ NO
Does the member have a diagnosis of alcohol use disorder?	☐ YES ☐ NO
Does the member have a history of illicit use of drugs by injection?	☐ YES ☐ NO
Has the member completed or is currently in a treatment program from an enrolled addiction medicine/chemical dependency provider (or buprenorphine waived provider if history of IV drug use)? Approximate Dates of Treatment (REQUIRED, if applicable):	☐ YES ☐ NO Attested by: ☐ PROVIDER ☐ PATIENT
Please provide the name of the enrolled addiction medicine/chemical dependency treatment provider/facility name, if applicable:	
Does the member have Hepatitis B?	☐ YES ☐ NO
If the member has Hepatitis B, has it been treated or will it be closely monitored during treatment?	☐ YES ☐ NO
Is the member post-liver transplant?	☐ YES ☐ NO
Is the member's life expectancy greater than one year?	☐ YES ☐ NO
Does the member attend scheduled visits with no more than 1 no-show and fill maintenance medications on time?	☐ YES ☐ NO
Does the member have any contraindications to therapy with the requested agent?	☐ YES ☐ NO
Is the member going to take Ribavirin alongside treatment?	☐ YES ☐ NO

Please confirm that all of the following is attached to the request, along with any other documentation required, as stated in the PDL:

- o Baseline HCV RNA
- o ≥ 2 drug and alcohol tests dated at least 3 months apart
- o Patient & Prescriber attestation forms
- o Chart notes addressing member's alcohol and drug free status over the past year
- o Documentation of member's fibrosis score if available (e.g. APRI, Fibroscan, Fibrotest)

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.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Hepatitis C Patient Consent Form

I,_____, have been counseled by my healthcare provider on the following:

I am planning to live in North Dakota during the entire treatment period. I will complete the entire course of treatment, attend office visits, and have laboratory tests as ordered by my healthcare provider during the treatment period.

I will notify my chosen pharmacy of a need to refill one week prior to running out of medication. I understand I must take my medication each day as directed for the entire course of treatment. If the medication does not work due to missed doses, I may not be approved for re-treatment.

I understand to keep my liver healthy, I must not drink alcohol or use illicit injectable drugs prior to, during, or after my treatment. If indicated, I will participate in a treatment program to remain abstinent.

I understand that after treatment, I can be re-infected with Hepatitis C. My provider has educated me on routes of Hepatitis C transmission, and I will avoid or modify high risk activities to avoid re-infection.

I understand that medications that treat Hepatitis C may be harmful to unborn babies. I will use methods to avoid getting pregnant or another person pregnant during treatment and when advised by my provider or pharmacist, for at least 6 months after treatment is complete.

Patient Signature_____Date __/__/____

Pharmacy or Prescriber Representative:

Signature _____Date __/__/____

By signature, the pharmacy or prescriber representative confirms the contract has been reviewed with the patient

Hepatitis C Prescriber Agreement Form

I agree that I will counsel my patient on how, where, and when to obtain refills on their hepatitis C medications.

I agree that I will have intermittent telephone check-ins with my patient, at minimum at 2 weeks and 6 weeks of treatment. I will assess continued adherence with medication, labs, and office visits, treatment tolerability, as well as medication changes that may affect treatment.

I have reviewed my patient's medications for drug interactions that would make Hepatitis C medications less effective or cause other adverse effects.

I have reviewed the treatment plan with my patient including medications, lab, vaccinations, and follow-up visits.

I have assessed my patient's readiness for treatment and believe they are ready and willing to comply with the treatment plan. I have assessed social and psychological stability, substance use abstinence, compliance to follow up visits and medications, pregnancy status, and concurrent health risks.

I understand that ND Medicaid tracks refill history and may contact me to provide additional information in the event of a dropped or late refill.

I have a dedicated individual or team which may include pharmacy and nursing support to fulfill the elements of this form and have listed key members contact information below.

Name: _____ Location: _____

Phone #: _____

Name: _____ Location: _____

Phone #: _____

Pharmacy or Prescriber Representative:

Signature_____ **Date** __/__/____