



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 patients receiving a prescription for hepatitis C treatments must meet the criteria listed in the preferred drug list (PDL). Please see the PDL at <http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf>:

- Please complete this form in its entirety and provide any and all required documentation (if available)

Part I: TO BE COMPLETED BY PHYSICIAN

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:		Patient's liver fibrosis score: <input type="checkbox"/> F0-F1 <input type="checkbox"/> F3-F4	
Diagnosis: <input type="checkbox"/> HCV <input type="checkbox"/> OTHER:		Genotype:		Patient's Child-Pugh Class: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> N/A	
Please list any previous treatments the patient has failed for chronic HCV: <input type="checkbox"/> N/A				Regimen:	Dates of treatment:
Has the patient remained drug (illicit use by injection) and alcohol free for the past 3 months?				<input type="checkbox"/> YES <input type="checkbox"/> NO	
Does patient have a diagnosis of alcohol use disorder?				<input type="checkbox"/> YES <input type="checkbox"/> NO	
Does patient have a history of illicit use of drugs by injection?				<input type="checkbox"/> YES <input type="checkbox"/> NO	
Has patient 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)?				<input type="checkbox"/> YES <input type="checkbox"/> NO	
Approximate Dates of Treatment:				Attested by: <input type="checkbox"/> PROVIDER <input type="checkbox"/> PATIENT	
Does the patient have Hepatitis B?				<input type="checkbox"/> YES <input type="checkbox"/> NO	
If the patient has Hepatitis B, has it been treated or will it be closely monitored during treatment?				<input type="checkbox"/> YES <input type="checkbox"/> NO	
Is the patient post-liver transplant?				<input type="checkbox"/> YES <input type="checkbox"/> NO	
Does the patient's life expectancy greater than one year?				<input type="checkbox"/> YES <input type="checkbox"/> NO	
Does patient attended scheduled visits with no more than 1 no-show and fill maintenance medications on time?				<input type="checkbox"/> YES <input type="checkbox"/> NO	
Does patient have any contraindications to therapy with the requested agent?				<input type="checkbox"/> YES <input type="checkbox"/> NO	
ONLY IF RIBAVIRIN IS BEING USED IN A PATIENT OF CHILD-BEARING POTENTIAL					
Has the patient had a negative pregnancy test in the last 30 days and will receive monthly pregnancy tests during treatment?				<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
Please confirm that all of the following is attached to the request, along with any other documentation required, as stated in the PDL:					
<input type="checkbox"/> Baseline HCV RNA		<input type="checkbox"/> HCV RNA 4 weeks after starting therapy (for renewal)			
<input type="checkbox"/> ≥ 2 drug and alcohol tests dated at least 3 months apart		<input type="checkbox"/> Chart notes addressing patient's alcohol and drug free status over the past year			
<input type="checkbox"/> Patient & Prescriber attestation forms		<input type="checkbox"/> Documentation of patient's fibrosis score if available (e.g. APRI, Fibroscan, Fibrotest)			
Prescriber (or Staff) / Pharmacy Signature**				Date	
<i>** 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 patient'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.</i>					

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** __/__/____