Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Hepatitis C Agents First Fill/Refill (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Hepatitis C Agents First Fill/Refill (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
DAKLINZA (daclatasvir)	EPCLUSA (sofosbuvir/velpatasvir)	HARVONI (ledipasvir/sofosbuvir)
MAVYRET (glecaprevir and pibrentasvir)	MODERIBA (ribavirin)	OLYSIO (simeprevir)
PEGASYS (peginterferon alfa-2a)	REBETOL (ribavirin)	RIBASPHERE (ribavirin)
SOVALDI (sofosbuvir)	TECHNIVIE (ombitasvir, paritaprevir and ritonavir)	VIEKIRA (ombitasvir, paritaprevir and ritonavir and dasabuvir)
VOSEVI (sofosbuvir)	ZEPATIER (elbasvir/grazoprevir)	OTHER:_____

Patient Information	
Patient Name:	
Patient ID:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
Directions for administration:	

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   If the answer to this question is yes, approved.
   If the answer to this question is no, go to question 2.

2. Is the request for reauthorization (i.e., previous authorization is on file under this plan) or for continuation of therapy? Y N
If the answer to this question is yes, go to question 3.
If the answer to this question is no, go to question 8.

3. Has the Texas Medicaid/CHIP Texas Vendor Drug Program Antiviral Agents for Hepatitis C Virus Refill Authorization Request been completed and submitted? Y N
If the answer to this question is yes, go to question 4.
If the answer to this question is no, denied.

4. Is the patient compliant with HCV treatment (has not missed more than 14 days of treatment)? Y N
If the answer to this question is yes, go to question 5.
If the answer to this question is no, denied.

5. Is the patient currently abusing alcohol/drugs? Y N
If the answer to this question is yes, go to question 6.
If the answer to this question is no, go to question 7.

6. Is the prescriber aware of positive drug test? Y N
If the answer to this question is yes, go to question 7.
If the answer to this question is no, go to question 7.

7. Has the provider submitted the required labs (and does the lab show decreased or undetected viral load at 4 weeks or 12 weeks)? Y N
If the answer to this question is yes, go to question 24.
If the answer to this question is no, denied.

8. Has the Texas Medicaid/CHIP Vendor Drug Program Patient Education for Hepatitis C Treatment Prescriber Certification form been submitted signed by both the physician and the patient? Y N
If the answer to this question is yes, go to question 9.
If the answer to this question is no, denied.

9. Is the prescribed treatment agent appropriate for the age of the patient? Y N
If the answer to this question is yes, go to question 10.
If the answer to this question is no, denied.

10. Does the patient have a diagnosis of Chronic Hepatitis C virus (HCV) with a confirmed genotype 1a 1b, 2, 3, 4, 5, or 6? (Genotype test results must be obtained within the previous 5 years from the date of prior authorization request.) Y N
If the answer to this question is yes, go to question 11.
If the answer to this question is no, denied.

11. If applicable, has the patient had a negative pregnancy test within the last 90 days? Y N
(Confirmation via pregnancy test is not required for female patients over the age of 50 or for those documented as not able to become pregnant. If not applicable, answer Yes.)
If the answer to this question is yes, go to question 12.
If the answer to this question is no, denied.

12. Does the patient have a drug test completed at least 90 days prior to starting treatment? Y N
Drug test to include both legal and illegal drugs which are not verifiable by prescription.
If the answer to this question is yes, go to question 13.
If the answer to this question is no, denied.

13. Has the patient been assessed for their Child-Turcotte-Pugh Score and hepatitis B status within the last 90 days? Y N
If the answer to this question is yes, go to question 14.
If the answer to this question is no, denied.

14. Has the provider submitted laboratory results from within the last 90 days for ALL of the following tests? Y N
    - Baseline HCV RNA level
    - Alanine aminotransferase (ALT)
    - Aspartate Aminotransferase (AST)
    - Alkaline phosphatase (AlkPhos)
    - Creatinine clearance (CrCl)
    - Serum creatinine (SCr)
    - Total bilirubin
    - International normalized ratio (INR)
    - Hematocrit (HCT)
    - Hemoglobin (HGB)
    - Red blood cell count (RBC)
    - Platelets (Plt)
    - Albumin

    If the answer to this question is yes, go to question 15.
    If the answer to this question is no, denied.

15. Are all the test in compliance with their respective critical values? If no, please document values and explanation. Y N
    If the answer to this question is yes, go to question 16.
    If the answer to this question is no, Document Rationale, Go to 16.

16. Does the member have hepatocellular carcinoma, or have they had a liver transplant? Y N
    If the answer to this question is yes, go to question 19.
    If the answer to this question is no, go to question 17.

17. Is the patient's METAVIR score F2, F3, or F4? Y N
    If the answer to this question is yes, go to question 18.
    If the answer to this question is no, denied.
    (NOTE TO REVIEWER: Medicaid enrollees with severe extrahepatic effects of chronic hepatitis C, treatment will be approved by the Medical Director on a case-by case basis.)

18. Does the member have a documented Metavir score (a liver biopsy from the past 5 years or one non-invasive tests (e.g., FibroSURE, Fibrospect, Fibrometer, Fibroscan, Fibrotest, or Sheer Wave Elastography) from the past 2 years)? Y N
    If the answer to this question is yes, go to question 19.
    If the answer to this question is no, denied.

19. Does the member have the following labs in the last 2 years? Y N
    - For Olysio drug requests, Q80K polymorphism testing
    - For Daklinza or Zepatier requests, NS5A resistance testing requests

    (NOTE TO REVIEWER: If not applicable to request, answer yes)
    If the answer to this question is yes, go to question 20.
    If the answer to this question is no, denied.

20. Are the medication(s) prescribed by, or in conjunction with, a board-certified gastroenterologist, hepatologist, or infectious disease specialist? If prescribed in conjunction with one of these specialists, please submit a copy of the written consultation. Y N
    If the answer to this question is yes, go to question 21.
    If the answer to this question is no, denied.

21. Are the requested drugs used for FDA approved indication per member's genotype? Y N
    If the answer to this question is yes, go to question 22.
    If the answer to this question is no, denied.

22. Does the patient have decompensated cirrhosis? Y N

If the answer to this question is yes, go to question 23.
If the answer to this question is no, go to question 24.

23. Is the request for Epclusa, or does the regimen include ribavirin? Y N
(NOTE TO REVIEWER: Epclusa is approved for ribavirin ineligible members.)
If the answer to this question is yes, go to question 24.
If the answer to this question is no, denied.

24. Is the request for 340B or a TX CHIP member? Y N
If the answer to this question is yes, approved.
If the answer to this question is no, go to question 25.

25. Is this request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 26.
If the answer to this question is no, approved.

26. Has the patient been stable on 1 non-preferred agent for 30-days in the past 180 days? Y N
If the answer to this question is yes, approved.
If the answer to this question is no, go to question 27.

27. Has the patient failed a 30 day treatment trial with at least 1 preferred agent(s) within the past 180 days? Y N
If the answer to this question is yes, approved.
If the answer to this question is no, go to question 28.

28. Is there a documented allergy or contraindication to preferred agents in this class? Y N
If the answer to this question is yes, approved.
If the answer to this question is no, go to question 29.

29. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
If the answer to this question is yes, approved.
If the answer to this question is no, denied.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

_____ _____
Prescriber (or Authorized) Signature Date