Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Hepatitis C Agents First Fill (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 (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)	

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. Has the patient been previously approved for hepatitis C therapy by Texas Medicaid or currently on treatment and is transitioning to Texas Medicaid? Y N
   If the answer to this question is yes, close PA and open HCV Refill PA.
   If the answer to this question is no, go to question 2.

2. 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 3.
   If the answer to this question is no, denied.

3. Is the patient at least 18 years of age?
   If the answer to this question is yes, go to question 5.
   If the answer to this question is no, go to question 4.

4. Is the patient equal to or older than 12 years of age and is the request for Harvoni? Y N
   If the answer to this question is yes, go to question 5.
   If the answer to this question is no, denied.

5. Does the patient have a diagnosis of Chronic Hepatitis C virus (HCV) with a confirmed genotype 1a, 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 6.
   If the answer to this question is no, denied.

6. 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 7.
   If the answer to this question is no, denied.

7. 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 8.
   If the answer to this question is no, denied.

8. 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 9.
   If the answer to this question is no, denied.

9. Has the physician submitted laboratory results for ALL of the following tests? Y N
   - Must be drawn within the last 90 days.
     - Baseline HCV RNA level
     - Alinine 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.

   - Must be drawn within the last 5 years.
     - HCV genotype
     - METAVIR score: Documentation of tests used to calculate METAVIR score must also be submitted. Either a liver biopsy or one non-invasive tests (e.g., FibroSURE, Fibrospect, Fibrometer, Fibroscan, Fibrotest, or Sheer Wave Elastography).

- Must be drawn within the last the last 2 years.
    - Q80K polymorphisom testing for Olysio request.
    - NS5A resistance testing for Daklinza or Zepatier requests.

If the answer to this question is yes, go to question 10.
If the answer to this question is no, denied.

10. Are all of the tests 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 11.
If the answer to this question is no, go to question 11.

11. 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 12.
If the answer to this question is no, denied.

12. Is the patient's METAVIR score F0, F1, or F2? Y N
If the answer to this question is yes, go to question 13.
If the answer to this question is no, go to question14.

13. Does the patient have hepatocellular carcinoma or previous liver transplant? Y N
If the answer to this question is yes, go to question 15.
If the answer to this question is no, denied.

14. Is the patient's METAVIR score F3 or F4? Y N
If the answer to this question is yes, go to question 15.
If the answer to this question is no, denied.

15. 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 16.
If the answer to this question is no, denied.

16. Does the patient have decompensated cirrhosis? Y N
If the answer to this question is yes, go to question 17.
If the answer to this question is no, go to question 18.

17. Is the request for Epclusa or does the regimen include ribavirin? Y N
Epclusa is approved for ribavirin ineligible members.
If the answer to this question is yes, go to question 18.
If the answer to this question is no, denied.

18. Is the request for a non-preferred agent? Y N
If the answer to this question is yes, go to question 19.
If the answer to this question is no, approved for 6 weeks.

19. 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 for 6 weeks.
If the answer to this question is no, go to question 20.

20. Has the patient failed a 30-day treatment trial with at least 1 preferred agent(s) within the past 180 days or has a documented allergy or contraindication to preferred agents in this class? Y N
If the answer to this question is yes, approved for 6 weeks.
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