Michigan Department of Health and Human Services (MDHHS)

# Prior Authorization Criteria for Hepatitis C Treatment: Current Treatment Criteria

- Providers are encouraged to complete the fax form located at https://michigan.fhsc.com/Providers/Forms.asp
- Preferred agents are noted on the Preferred Drug List: https://michigan.fhsc.com/Providers/DrugInfo.asp

<u>The patient must meet the following criteria for treatment coverage of hepatitis C:</u>

1. The patient must be 18 years of age or older.
2. The patient must have the diagnosis of chronic hepatitis C.

For initial requests:

1. The patient's RNA viral load must be documented prior to initiation of treatment (lab results must be submitted).
2. The Genotype must be obtained (lab results preferred).
3. The patient must have one of the following:
    1. HIV co-infection
    2. Prior liver transplant
    3. Serious extra hepatic manifestation of hepatitis C , such as cryoglobulinemia or membranoproliferative glomerulonephritis
    4. Metavir fibrosis score consistent with a Metavir score of F3 or F4 as documented by one of the following (supporting documentation must be submitted):
        - Serum marker supporting a level of fibrosis of F3/F4 [APRI $\geq$ 1.5, FIB-4 $\geq$ 3.25, Fibrotest/Fibrosure $\geq$ 0.59 (scores must be calculated where appropriate with supporting labs submitted)] **or**
        - Fibroscan $\geq$ 9.5 **or**
        - Liver biopsy demonstrating F3 or F4 (report must be submitted) **or**
        - Ultrasound/ MRI or CT of the abdomen which demonstrates one of the following documented in the radiology report: cirrhosis, esophageal varices, ascites, splenomegaly **or**
        - Clinical signs and symptoms consistent with substantial or advanced fibrosis or cirrhosis
            - History of hepatic encephalopathy requiring treatment with medication or hospitalization within the past 12 months
            - History of portal hypertension as demonstrated by variceal bleeding or radiographic evidence of a transjugular intrahepatic portsystemic shunt (TIPS) procedure
            - Ascites

4. Lab testing **(copy of results must be submitted unless otherwise noted):**
    - Genotype (preferred, but not required)
    - Detectable HCV RNA viral load (within one year of treatment initiation)
    - ALT/AST (within three months of treatment initiation)
    - CBC (within three months of treatment initiation)
    - GFR (within three months of treatment initiation)
5. The medication must be prescribed by a gastroenterologist, hepatologist, liver transplant or infectious disease physician. If the prescribing provider is not one of the identified specialists noted, the prescriber must submit documentation of consultation/collaboration of the specific case with one of the afore-mentioned specialists which reflects discussion of the history and agreement with the plan of care with the date noted in the progress note.
6. Documentation of the patient's abuse of IV drugs or alcohol must be noted (i.e., current abuse of IV drugs or alcohol or abuse within the past 6 months). The Department will consider this in terms of optimizing treatment.
7. Documentation of commitment to the planned course of treatment and monitoring (including SVR 12) as well as patient education addressing ways to reduce the risks for re-infection must be submitted.
8. Patients with a Metavir F4 score must have liver imaging (preferably an abdominal ultrasound or CT, but MRI accepted) with results for hepatocellular carcinoma (HCC) surveillance submitted. If positive for HCC, please indicate how this will be addressed in the plan of care.

For renewal requests:

The patient's most recent RNA viral load must be documented and must show a 2 log decrease or be undetectable by treatment week 12.

# Michigan Department of Health and Human Services (MDHHS)
## Prior Authorization Request
### Hepatitis C Medications

**All information on this form must be addressed. Incomplete forms will be returned only once for missing information. Mark as 'N/A' if no information is available or does not apply.**

### *Prescribing Physician*

**LAST NAME:**

**FIRST NAME:**

**PLEASE SELECT ONE:**

☐ MD ☐ DO ☐ NP ☐ PA

**PHONE NUMBER:** ___ – ___ – ____

**FAX NUMBER:** ___ – ___ – ____

**NPI NUMBER:**

### *Beneficiary*

**LAST NAME:**

**FIRST NAME:**

**DATE OF BIRTH:** __ – __ – ____

**SEX:** ☐ Male ☐ Female

**MEDICAID NUMBER:**

### *Person Completing Form*

**LAST NAME:**

**FIRST NAME:**

**TITLE:** _____ **DATE:** _____ **REQUESTED START DATE:** _____

### *Pharmacy*

**NAME:** _____

**PHONE NUMBER:** ___ – ___ – ____

**Please complete this form and submit along with the following required documentation: genotype, HCV RNA value, test or lab that documents the level of liver fibrosis/Metavir score, liver imaging results and, if applicable, a dated progress note reflecting collaborative agreement with specialist for this specific patient.**

***SVR12 results must be available upon request by Michigan Medicaid.***

### *Drug Information*

| Drug Name, Dosage Form & Strength | Quantity Dispensed: | Duration of Therapy: |
|---|---|---|
| | | |
| | | |

### *Prescriber's Specialty*
***(The prescriber must be a GI, ID specialist or a Hepatologist, otherwise collaboration/consultation is expected.)***

**Indicate the prescriber's specialty:**

☐ **Gastroenterologist** ☐ **Hepatologist** ☐ **Infectious disease** ☐ **Liver Transplant Specialist**

**For providers not identified above: If the prescribing provider is not one of the above listed specialists, it is expected the prescriber has collaborated /Consulted with one of the above noted specialists. Please identify the specialty of the prescriber**

☐ **Internal medicine** ☐ **Family medicine** ☐ **NP** ☐ **PA** ☐ **Other**_____

**Consulting/collaborating specialist name:** _____

**In addition, please include supporting documentation that demonstrates consultation/collaboration with the specialist (e.g. consult notes, progress notes.)**

Submit requests to:
Magellan Medicaid Administration
11013 W Broad Street Suite 500, Glen Allen, VA 23060
Fax: 888-603-7696 Phone: 877-864-9014
This form is available at michigan.fhsc.com → Providers → Forms



**Revision Date**: 05/2016

Magellan Rx MANAGEMENT℠

# Michigan Department of Health and Human Services (MDHHS)
## Prior Authorization Request
### Hepatitis C Medications

**Diagnosis**

☐ Chronic Hepatitis C ☐ Compensated cirrhosis ☐ Decompensated cirrhosis (Child-Pugh score class B or C)

☐ Hepatocellular carcinoma ☐ Status post-liver transplant

☐ Treatment naïve ☐ Treatment Experienced ( ☐ Interferon; ☐ Direct-Acting Antivirals (DAAs))

HCV Genotype: ☐ 1a (polymorphism ☐ Yes ☐ No ☐ N/A; *If yes, submit test results*) ☐ 1b, ☐ 2, ☐ 3, ☐ 4, ☐ 5, ☐ 6

Choose one: ☐ Treatment initiation ☐ Continuation of therapy, current week _____

**Diagnostic/Disease Severity Evidence**

*Indicate and submit supporting documentation for:*

APRI Score: _____ FIB4 Score: _____

Metavir score: ☐ F0 - F2 ☐ F3 ☐ F4

If metavir F4, please submit most recent liver imaging results (i.e., ultrasound, CT scan) to access for hepatocelluar carcinoma.

*Select the following if known:*

☐ Ultrasound based transient elastography (Fibroscan) score ≥ 9.5 ☐ Fibrotest (FibroSure) score of ≥ 0.59

☐ Ascites ☐ Esophageal varices ☐ Splenomegaly ☐ Hepatic Encephalopathy (within past 12 months)

☐ Transjugular Intrahepatic Portsystemic Shunt (TIPS) ☐ Biopsy, results_____

**Lab Values**

Initial Baseline: HCV RNA value: _____ date drawn: _____
(Must be within the past 12 months)

For renewals, has viral load reached a 2-log decrease or undetectable level? ☐ Yes ☐ No

Week:_____ HCV RNA value: _____ date drawn: _____

**Other Co-morbid condition(s), if appropriate**

HIV: ☐ Yes ☐ No

History of severe renal impairment (eGFR<30 mL/min/1.73m$^2$) or end stage renal disease requiring hemodialysis: ☐ Yes ☐ No

Other: ☐ Yes ☐ No

If yes to any, please give details: _____

**Social History**

Is patient currently abusing IV drugs or alcohol? ☐ Yes ☐ No
If no, has patient been abstinent for 6 months? ☐ Yes ☐ No

**Adherence**

Does the patient have a current treatment plan that includes the following: ☐ Yes ☐ No

- Documented commitment to adherence with the planned course of treatment and monitoring.
- Documentation of counseling on how to reduce the risks for re-infection.



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