FAX completed form to
Change Healthcare
1-866-964-3472

Wyoming Medicaid – Pharmacy Services Program
PRIOR AUTHORIZATION REQUEST FORM

Hepatitis C Treatment

PHONE:
(For questions or inquiries ONLY)
1-877-207-1126

Provider must fill in all information below. It must be legible, correct and complete or the form will be returned.

Client ID #: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Client's Full Name: _____ DOB: ___/___/_____

Prescriber NPI: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Prescriber's Full Name: _____ Phone: _____

Prescriber Address: _____ Fax: _____

Pharmacy NPI: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Pharmacy Name: _____ Phone: _____

Drug Name (List one drug per form)	**Strength**	**Dosage Instructions**	**Days Supply**	**Quantity**	**Refills**

1. **Has the client had a drug screening performed within the last thirty days?** ☐ **Yes** ☐ **No**
   If yes, please include screening results and date with the completed prior authorization form. ***If the drug screen is positive for illicit drugs or does not match the client's drug profile, additional information will be requested during the evaluation of the prior authorization request.***

2. **Has the client had an HIV test performed within the last thirty days?** ☐ **Yes** ☐ **No**
   If yes, please include test results and date with the completed prior authorization form.

3. **Has the client had a Hepatitis B test performed within the last thirty days?** ☐ **Yes** ☐ **No**
   If yes, please include the test results and date with the completed prior authorization form.

4. **Has the client completed the PREP-C (Psychosocial Readiness Evaluation and Preparation for Hepatitis C Treatment) survey?** ☐ **Yes** ☐ **No**
   If yes, please include results and date with the completed prior authorization form. The PREP-C survey can be obtained at **https://prepc.org**.

5. **Have the client and the prescriber completed the Wyoming Medicaid Client Disclosure and Commitment to Take Hepatitis C Medications form?** ☐ **Yes** ☐ **No**
   If yes, please include this form with the completed prior authorization form.

***** If no is circled for questions 1-5 above, the prior authorization request will be deferred until the step(s) is/are completed and the required documentation has been submitted to CHC.**

6. **Does the client have cirrhosis? □ Yes □ No**

7. **If yes, is the cirrhosis compensated or decompensated? _____**

8. **Client's Hepatitis C Genotype_____**

9. **Please list any other Hepatitis C medications that will be given concurrently with the requested medication above as well as anticipated length of treatment.**

	Medication	**Anticipated Length of Use**
A.	_____	_____
B.	_____	_____

10. **Is this client Hepatitis C treatment naïve? □ Yes □ No**

If no, please list previous treatments below:

	Medication	**Dates of use**	**Reason for Discontinuing**
A.	_____	_____	_____
B.	_____	_____	_____

*****All clients that are approved for treatment of Hepatitis C will be referred to the Pharmacy Care Management (PCM) program for case management. Please note that SVR 12 results will be required to be submitted to the PCM program after treatment has been completed. Wyoming Medicaid will only cover one course of treatment per client.***

Prescriber Signature: _____ Date(s) of Submission: _____

**** Prescriber's original signature required; copied, stamped, or e-signatures are not allowed. By signature, the prescriber confirms the criteria information above is accurate and verifiable in client records.***

Wyoming Medicaid Client Disclosure and Commitment to Take Hepatitis C Medications

Please initial each statement that you have read and discussed the "Disclosure and Commitment to Take Hepatitis C Medications" form with your healthcare provider.

___ I understand that I will be taking very potent and expensive Hepatitis C medication(s). After discussion of the nature, alternatives, risks and benefits of these medications with my prescriber, I agree to take them as instructed. I understand that this combination of medication is to manage my Hepatitis C and has shown a high chance of a successful response in the treatment of Hepatitis C when taken appropriately.

___ I understand that there are risks to not treating chronic Hepatitis C, including disease progression, developing cirrhosis, liver cancer and liver failure. I also understand there are risks and hazards related to the use of these medications. The risks and benefits have been reviewed and discussed with me by my prescriber.

___ I will commit to the following processes to help make this treatment successful:
□ Daily adherence to medication unless told by prescriber/pharmacy to stop medication
□ Timely laboratory monitoring per prescriber's request
□ Medication counseling, education and training regarding administration and side effects
□ Telephone follow-ups with prescriber, pharmacy, Medicaid and the Pharmacy Care Management program
□ No missed follow-up appointments with prescriber during this treatment

___ I understand that if I am not committed to this regimen that I put myself in jeopardy with treatment failure and denial of medication coverage for this particular regimen by Wyoming Medicaid. I understand that only one course of therapy is allowed in my Wyoming Medicaid lifetime.
___ I have been given an opportunity to ask questions about my condition, alternative treatment options and risks of treatment, and I believe that I have sufficient information to understand the content of this disclosure and commitment to this treatment option.
___ I understand no warranty of guarantee has been made to me as a result of using this drug of the possibility of curing my condition. I acknowledge that I have been given a copy of this completed commitment form. I willingly give commitment to the following regimen.

□ **Harvoni 90/400 mg** by mouth once daily
□ **Epclusa 400/100 mg** by mouth once daily
□ **Mavyret 100/40 mg** three tablets by mouth once daily
□ **Other: _____**
*Please note:
Zepatier requires testing for NS5A polymorphism

□ Projected start date if regimen is approved by insurance: _____ Duration: _____ weeks

Client Name: _____ Client Signature: _____ Date: _____ Client Phone Number: _____

I, the undersigned prescriber, do hereby affirm that I have disclosed all of the above statements with full explanation to the client. I have specifically explained that Wyoming Medicaid will only cover one such treatment for the client, and non-compliance with the prescribed Hepatitis C regimen may put the client in jeopardy for denial of coverage in the future.

Prescriber Signature: _____ Date: _____
**** Prescriber's original signature required; copied, stamped, or e-signatures are not allowed. By signature, the prescriber confirms the criteria information above is accurate and verifiable in client records.***

Please fax completed form with the prior authorization request to Change Healthcare: 866-964-3472. For any other questions, please call the Change Healthcare Help Desk at 877-209-1264.