

Texas Vendor Drug Program
**Antiviral Agents for Hepatitis C Virus Initial
Authorization Request (Medicaid)**

Part I. Prior Authorization Criteria and Policy

I. Eligibility

1. Patient is enrolled in Texas Medicaid.
2. The prescribed treatment agent is appropriate for the age of the patient.
3. Patient has a diagnosis of chronic hepatitis C virus (HCV).
4. Confirmed genotype of 1a, 1b, 2, 3, 4, 5 or 6 if the treatment agent is not pangenotypic. Genotype test results must be obtained within the previous 5 years from the date of prior authorization request.
5. Required laboratory values in Section 4b through 4d of the prior authorization form must be obtained within 90 days prior to the request for HCV treatment.
6. Female patients' pregnancy status must be determined by a pregnancy test prior to the request for HCV treatment. Conduct the pregnancy test as close to the start of treatment as possible, but no later than 90 days prior to the request. Pregnancy status must be confirmed negative for all ribavirin containing regimens. Pregnancy status is not required for those over 50, or for those documented as not able to become pregnant.
7. Patient must be assessed for hepatitis B coinfection within 90 days prior to the request for HCV treatment.
8. Documentation of any additional supporting labs must be provided if requested by the patient's health care plan.

II. Treatment approval

1. Prescriptions may be dispensed for a maximum 28-day supply.
2. Request for products other than a preferred product will require additional justification, including rationale for why a preferred product is not indicated for the patient. Request for a product other than a preferred product does not guarantee approval.

Preferred Products based on Vendor Drug Program (VDP) Preferred Drug List (STAR/STAR KIDS Only): Requests for a non-preferred drug must meet at least one (1) of the below:

- Patient has been stable on one (1) non-preferred agent for 30-days in the last 180 days
- Patient failed a 30-day treatment trial with at least one (1) preferred agent in the last 180 days
- Patient has a documented allergy or contraindication to preferred agents in this class
- The drug is necessary for treatment of stage-4 advanced metastatic cancer and associated conditions

Preferred Products
<ul style="list-style-type: none"> • Epclusa (sofosbuvir/velpatasvir)* • Mavyret (glecaprevir/pibrentasvir)* • Vosevi (Sofosbuvir/velpatasvir/voxilaprevir)*
*See package insert for FDA indications

3. Regimen approval is based on genotype if applicable, disease related conditions, concurrent drug therapies and previous HCV treatment regimens.
4. Patients who transition to Medicaid from another health care plan while currently undergoing active HCV treatment will be allowed to continue the HCV treatment regimen without interruption regardless of drug status (preferred or non-preferred).
5. Prescriber and patient must review and sign the *Prescriber Certification* document.
6. Submission of incomplete or missing forms may result in denial of the request.

III. Additional Considerations

1. Patient's non-adherence to therapy for more than 14 days may result in discontinuation of prior authorization and additional refills may not be approved. Exceptions are considered in circumstances beyond patient or prescriber control. Documentation stating reason for gaps in therapy may be required at the request of the health plan.
2. Patients requiring retreatment will be assessed for approval on a case by case basis.
3. Lost or stolen medications may not be replaced.
4. For appeals and reconsiderations, dates of any test or laboratory results falling outside of the required windows for submission will be considered valid if the date of the test, laboratory results or both were within the required window for submission at the time of the initial HCV prior authorization request. This policy is not applicable if more than 90 days have passed since the initial HCV prior authorization request.
5. HCV viral load is recommended at 12 weeks following completion of therapy. Prescribers should obtain and maintain records of viral load at 12 weeks after completion of therapy.

Part II. Prescriber Certification of Patient Education for Hepatitis C Treatment

Please read Part I (**Prior Authorization Criteria and Policy**) prior to signing this document. Please sign and fax Part II and Part III (**Initial Prior Authorization Request**) to Navitus at (855)-668-8553.

As the prescriber, I agree to provide verbal and written educational information about chronic hepatitis C virus (HCV) and current treatment options, including but not limited to the following:

Prevention of HCV re-infection and human immunodeficiency virus (HIV) transmission

- Patients should abstain from injection drug use.
- Other methods of transmission, include needle sharing, sex with infected partners, sharing personal items that might have blood on them such as razors or toothbrushes, or exposure to infected blood and body fluids via cuts or sores on the skin.

Prevention of liver disease progression

- HCV-positive persons should be advised to avoid alcohol because it can accelerate liver disease. Abstinence from alcohol and, when appropriate, interventions to facilitate cessation of alcohol consumption should be advised for all persons with HCV infection.
- The CDC recommends Hepatitis A and B vaccines as well as a yearly influenza vaccine for those with HCV infection. [cdc.gov/vaccines/schedules/](https://www.cdc.gov/vaccines/schedules/).
- Cases of hepatitis B virus (HBV) reactivation have been reported in HCV/HBV co-infected patients. Patients should be assessed for HBV reactivation at regular intervals, but no more frequently than every 4 weeks.
- Take only medications approved by a health care professional. Prescription drugs as well as over the counter medications and herbal medicines may cause further damage to the liver.
- A buildup of fat in the liver can cause further liver damage. Eating healthy and working out can help patients lose weight and maintain a healthy weight. HCV infected persons who are overweight or obese should be counseled regarding strategies to reduce weight and improve insulin resistance via diet, exercise, or medical therapies.

Drug treatment process

- Patient should provide accurate contact information with a secondary contact for backup.
- Adherence to the drug regimen is critical to successful treatment. Medicaid may deny a refill or authorization request due to failure to refill the medication in a timely manner, defined as a refill greater than 14 days late. Failure to comply with therapy may result in treatment denial.
- Appropriate education regarding dosage administration, missed doses, food affects, side effects and adverse events related to selected treatment regimen, and therapy duration must be provided prior to treatment initiation.
- Pregnancy is contraindicated during treatment with regimens containing ribavirin. Women of childbearing age should be counseled not to become pregnant while receiving ribavirin-containing regimens, and for up to 6 months after stopping. Two methods of contraception are recommended during drug treatment. Estrogen based therapies may be contraindicated. Estrogen therapy should be replaced with progestin therapy if appropriate.
- HCV infected persons should check with a health care professional before taking any new prescription drug, over the counter drugs, or herbal or nutritional supplements to monitor for potential drug interactions.

Additional information

- Prescriber agrees to provide supporting documentation for any information on the form if requested by patient's health plan, provided the request is in compliance with HIPAA.
- Failure to provide required labs or requested documents may result in treatment denial.
- Patient education information and printable documents may be found at cdc.gov/hepatitis/ and hepatitis.va.gov/products/patient/brochures-index.asp.

Patient support programs

Patient support programs offer various levels of support throughout HCV treatment and some, after treatment completion. These programs are supported by drug manufacturers, and are run independently of Texas Medicaid. Patients may obtain benefit from enrolling in the program specific to the patient's drug regimen.

- Abbvie
 - Mavyret Nurse Ambassadors and Patient Support
 - Website: Mavyret.com/complete-patient-support
 - Phone: 877-Mavyret (877-628-9738)
 - Website: viekira.com/proceed-program
 - Phone: 844-2proceed (844-277-6233)
- Bristol-Myers Squibb
 - Website: patientsupportconnect.bmscustomerconnect.co
 - Phone: 844-44-Connect (844-442-6663)
- Gilead
 - Website: mysupportpath.com/
 - Phone: 855-7-MYPATH (855-769-7284)
- Merck
 - Website: zepatier.com/c-ahead/
 - Phone: 866-251-6013

Prescriber acknowledgment

By signing below, I agree I have explained the contents of this document, provided written and verbal education to the patient, and answered any questions the patient may have regarding their Hepatitis C treatment.

Prescriber Printed Name

Prescriber Signature

Date

Patient acknowledgment

By signing below, I agree the doctor has explained the contents of this letter and answered any questions I have regarding my Hepatitis C treatment.

Patient Printed Name

Patient Signature

Date

Part III. Initial Prior Authorization Request

Please complete and **fax all required documents to Navitus at (855) 668-8553** for initial prior authorization requests.

This form is only for people enrolled in Medicaid fee-for-service. If the person is enrolled in managed care, please contact the appropriate health plan for forms and instructions.

1. Patient Information

Name (Last, First):		Medicaid ID No.:	Diagnosis (ICD-10):
Date of Initial Diagnosis:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Current Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg

2. Prescriber Information

Name:	NPI No.:	State License No.:
Area Code and Telephone No.:	Area Code and Fax No.:	

3. Current Patient Status (Check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> Hepatocellular carcinoma | <input type="checkbox"/> HIV co-infection | <input type="checkbox"/> Hepatitis B co-infection |
| <input type="checkbox"/> Awaiting liver transplant | <input type="checkbox"/> Previous liver transplant(s) | <input type="checkbox"/> Compensated cirrhosis |
| <input type="checkbox"/> Decompensated cirrhosis | <input type="checkbox"/> End stage renal disease requiring hemodialysis | <input type="checkbox"/> Null responder |
| <input type="checkbox"/> Partial responder | <input type="checkbox"/> Relapsed | <input type="checkbox"/> None of the above |

a. If patient has been previously treated for HCV, is the previous treatment regimen(s) known? Yes No N/A

If yes, list medications used and any known dates of treatment below.

4. Additional Required Information

a. HCV Genotype if applicable:

- 1a 1b 2 3 4 5 6

Date of testing: _____
(Results must be from previous 5 years)

Results for items b through d, below, must be from the previous 90 days

b. Child-Turcotte-Pugh Score

- A (5-6 points) B (7-9 points) N/A

Date of testing: _____

c. Pregnancy Test:

- Positive Negative N/A

Date of testing: _____

d. Has the patient been assessed for hepatitis B virus coinfection?

- Yes* No

Date of testing: _____

*If yes, does the patient require concurrent hepatitis B virus treatment? Yes No

5. Prescribing Information

Preferred Products
<ul style="list-style-type: none"> • Epclusa (sofosbuvir/velpatasvir)* • Mavyret (glecaprevir/pibrentasvir) • Vosevi (Sofosbuvir/velpatasvir/voxilaprevir)
*See package insert for FDA indications

In the table below, specify all drug(s) being requested in the hepatitis C regimen and indicate the duration of therapy.

Requested Drug Name(s)	Requested Duration of Therapy (Weeks)
1.	
2.	
3.	

Selection of products other than the preferred products above may be appropriate for patients in whom a preferred regimen is not indicated. Request for a product other than a preferred product does not guarantee coverage. If requesting a product other than a preferred product from above, please provide the rationale below. **Failure to provide justification may result in denial of prior authorization.**

6. Required documents for submission for initial prior authorization requests:

- Completed Initial Authorization Request
 Completed Prescriber Certification Copy

7. Prescriber Signature

Provider Signature: _____ Date: _____

Provider signature indicates provider attests to all information outlined in Parts I (Prior Authorization Criteria), II (Prescriber Certification of Patient Education for Hepatitis C Treatment), and III (Initial Prior Authorization Request) of Form 1335.