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 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.

2. **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.

3. **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**.

4. **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 1-4 above, the prior authorization request will be deferred until the step(s) is/are completed and the required documentation has been submitted to CHC.**

5. **Does the client have cirrhosis?** ☐ **Yes** ☐ **No**

6. **If yes, is the cirrhosis compensated or decompensated?** ______________________________

7. **Client's Hepatitis C Genotype**____________________________________

8. **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.	______________________________	______________________________

9. **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. 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.