Nevada Medication Assistance Program (NV MAP)
For ALL Nevada AIDS Drug Assistance Program (ADAP) Members
Prior Authorization for Hepatitis C Treatment Regimens

APPLICATION INFORMATION

Ramsell is the contracted PBM service provider for Nevada Medication Assistance Program (NV MAP). Requests for the prior authorization of Hepatitis C therapy will be reviewed for appropriateness of therapy by the Pharmacists in the Ramsell Clinical Services Department.

Please complete the attached supplemental form for Hepatitis C Treatment Regimens and fax to Ramsell at 800-848-4241. The request must include all of the supporting lab results and chart documentation for approval. For provider's questions regarding HCV treatment access, call Ramsell at 888-311-7632, Clinical Services Department.

FINANCIAL ELIGIBILITY

Patients must have current, non-temporary eligibility for a minimum of 8 weeks with the Nevada MAP program to be considered for coverage. They must maintain program coverage throughout the course of Hepatitis C treatment. If Nevada MAP has not confirmed eligibility at the time of the request, the application will be denied.

Approval Period: Authorization to receive Hepatitis C treatments are dependent upon the genotype, prior treatment regimens and/or a history of advanced liver disease (cirrhosis).

Limits: Treatment for Hepatitis C regimens are limited by program funding. Approval of this application is dependent on availability of Nevada ADAP funding.

Approval notification: Clinicians will be notified of the approval decision via fax along with the pharmacy noted on the form.

CLINICAL ELIGIBILITY

All supporting laboratory results and chart notes are **REQUIRED**:

- ☐ Baseline Complete Blood Count
- ☐ Hepatitis C Genotype
- ☐ Baseline Hepatitis C RNA viral load (within the last 3 months)
- ☐ CD4 count (within the last 6 months)
- ☐ HIV viral load (within the last 6 months)

If the patient has cirrhosis, please provide documentation to support the diagnosis of cirrhosis. Some examples include fibrosis staging, liver biopsy results and Child Pugh scoring:

- ☐ Fibrosis staging (METAVIR, FibroSure,etc)
- ☐ Liver biopsy results
- ☐ Child Pugh Score

Additional information: For the latest Hepatitis C treatment recommendations consult the American Association for the Study of Liver Diseases (AASLD)/Infectious Diseases Society of America (IDSA) Hepatitis C Treatment Guidelines at www.hcvguidelines.org.

Nevada Medication Assistance Program
Supplemental Form for Hepatitis C Treatment Regimens
TELEPHONE: 888-311-7632 FAX: 800-848-4241

Please complete the appropriate sections below for determination of treatment authorization

Patient Name_____
Last Name First Name

Member ID _____

DOB_____ Height _____Weight_____

CD4 count _____ HIV viral load _____

Baseline Hepatitis RNA _____

Prescribing Physician _____

Prescriber NPI # _____ Specialty _____

Physician Phone # _____Fax#_____

Pharmacy Name _____

NABP# _____Contact Person _____

Pharmacy Phone# _____Fax# _____

_____ _____
Name of pharmacist or physician Date

_____ _____
Signature of pharmacist or physician Date

By signing above, you attest that all statements on this form are true to the best of your knowledge.

All supporting labs and chart documentation are REQUIRED for approval of this request.

Does this patient have diagnosis of Chronic Hepatitis C? ☐ **Yes** ☐ **No**

What is the Hepatitis C Genotype? (circle): 1a 1b 2 3 4 5 6

Has this patient been treated for Hepatitis C previously? (check all that apply)

- ☐ None (Treatment naïve)
- ☐ Prior PEG/ribavirin regimen Date: _____
- ☐ Prior NS5A Inhibitor DAA experienced – Drug:_____ Date: _____
- ☐ Prior Non-NS5A Inhibitor, Sofosbuvir-containing regimen Date: _____
- ☐ Prior NS3 Protease Inhibitor (telaprevir (Incivek®), boceprevir (Vitrelis®), or simeprevir (Olysio®) + PEG/Ribavirin experienced) Date:_____

What is the planned treatment regimen and duration? (Please fill in):

Drug Name(s) including strength :

_____

Daily Dosing: _____

Duration of therapy (weeks): _____

Please confirm the following statements: (check all that apply)

- ☐ This patient is on a stable antiretroviral regimen for HIV with HIV viral load < 200 copies/mL
- ☐ This patient has failed multiple trials of antiretroviral therapy due to advanced liver disease precluding antiretroviral treatment prior to HCV treatment.
- ☐ This patient has been tested for current or prior HBV infection (if treating with DAA)

If the patient has advanced liver disease, please answer the following questions.

Does this patient have a history of cirrhosis? ☐ YES ☐ NO

Does this patient have decompensated liver disease? ☐ YES ☐ NO

For All

- ☐ I agree to submit HCV RNA result from 12 weeks after treatment completion for program evaluation purposes (FAX to Ramsell)
- ☐ I have reviewed the clinical information on the proposed prescription for possible drug-drug interactions with other medications currently prescribed to the patient

REQUIRED DOCUMENTATION - Please submit ALL required clinical notes/ lab reports in reference to this request. Failure to provide documentation will delay decision process.

- ☐ Hepatitis C Genotype
- ☐ CD4 count (within the last 6 months)
- ☐ Hepatitis C RNA viral load (within the last 3 months)
- ☐ HIV viral load (within the last 6 months)