

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Hepatitis C Drug Prior Authorization

Use this form to request prior authorization (PA) for Daklinza, Eplusa, Harvoni, Olysio, Sovaldi, Technivie, Viekira Pak, Viekira XR, Zepatier. The Minnesota Department of Human Services contracts with Health Information Designs (HID), the MHCP prescription drug PA review agent, to provide drug prior authorization services. Direct all inquiries about PAs – including questions on criteria and status of PA – to HID. Call the MHCP Provider Call Center at 651-431-2700 or 800-366-5411 for all other inquiries, including questions about claims or refill-too-soon overrides. Access criteria information and forms through the MHCP Pharmacy website at www.dhs.state.mn.us/provider/pharm.

Obtain authorization by faxing the completed form or calling HID, the MHCP prescription drug PA review agent with the information below.

MHCP Prescription Drug PA Review Agent – HID

Hours: Monday–Friday, 8:00 a.m. to 5:30 p.m.

Phone: 866-205-2818 **Fax:** 866-648-4574

You must have this information available before you call or fax HID.

Fields in bold font are required before HID can issue PA. We will return incomplete forms.

Requestor Information

REQUESTOR NAME	REQUESTOR PHONE NUMBER (include area code)	REQUESTOR AFFILIATION (check one) Pharmacy Prescriber
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Renewal of expired authorization – PA # of expired authorization _____	New request
Copy-only authorization – Amount paid by primary insurance _____	
Patient between prepaid health plans Other (specify) _____	

PHARMACY NAME	PHARMACY NPI	PHONE NUMBER (include area code)	FAX NUMBER (include area code)
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PRESCRIBER NAME	PRESCRIBER NPI	PHONE NUMBER (include area code)	FAX NUMBER (include area code)
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DRUG NAME AND STRENGTH	NDC	QUANTITY	REFILLS
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DIRECTIONS	AUTH START DATE (m/d/yyyy)
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RECIPIENT NAME	RECIPIENT MA ID NUMBER	RECIPIENT DATE OF BIRTH (m/d/yyyy)
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DIAGNOSIS

OTHER MEDICATIONS TRIED AND DATE OF OTHER MEDICATION TRIALS FOR THIS CONDITION

DOCUMENTATION OF STATUS CHANGE OR ADVERSE REACTION CAUSED BY TRIALS OF OTHER MEDICATION(S)

(CHART DOCUMENTATION MAY BE ATTACHED)

LIST ALL CURRENT MEDICATIONS

(CHART DOCUMENTATION MAY BE ATTACHED)

Preferred Drug – Required Information

Are you a physician specializing in gastroenterology, hepatology or infectious disease?	Yes	No	IF YES, INDICATE SPECIALTY
Are you a physician assistant or nurse practitioner specializing in treating hepatitis C?	Yes	No	IF YES, INDICATE SPECIALTY
If you are not one of the above provider types, have you consulted with an HCV specialist? If yes, please provide consult notes with request.	Yes	No	Not Applicable
Do you attest that you have evaluated the patient for readiness for treatment, including identification of potential impediments to effective treatment (for example, adequate social support, missing appointments, stable behavioral health status, alcohol use disorder, IV drug use, difficulties with compliance)?	Yes	No	
Have you addressed the potential impediments to effective treatment in your chart notes before initiating treatment and submitting your notes with the prior authorization request?	Yes	No	
Has patient abstained from alcohol use for 6 months?	Yes	No	
Has patient abstained from alcohol use for 3 months?	Yes	No	
Is the patient receiving treatment at an approved facility and agreed to abstain from alcohol use during treatment?	Yes	No	
Is the patient under the care of an addiction medicine or chemical dependency treatment provider and do you attest that the patient has agreed to abstain from alcohol use during treatment?	Yes	No	
Has the patient abstained from IV drug use for 6 months?	Yes	No	
Has the patient abstained from IV drug use for 3 months?	Yes	No	
Is the patient receiving chemical dependency treatment?	Yes	No	
Has the chemical dependency treatment provider attested that the patient has abstained from IV drug use for 3 months?	Yes	No	
Has the chemical dependency treatment provider attested to having completed and reviewed a urine toxicity screen within 30 days prior to treatment initiation?	Yes	No	
Is the patient 18 years of age or older?	Yes	No	
What is the genotype and subtype of the patients HCV?	GENOTYPE		SUBTYPE
What is the pretreatment HCV RNA load (IU/L)?	HCV RNA VIRAL LOAD WITH DATE		
If genotype 1A, does patient have baseline NS5A polymorphism? Lab result must be provided.	Yes	No	
Does the patient have cirrhosis?	Yes	No	
Will you provide the outcome of treatment (SVR12) to the Department of Human Services via fax at 651-431-7424 when you obtain results?	Yes	No	

Is the patient pregnant?	Yes	No
Is the patient on dialysis?	Yes	No
What is the patient's CrCL or calculated CrCl?	CrCL or CALCULATED CrCL SCORE	
What is the patient's MELD or CPT score?	MELD SCORE	CPT SCORE

Non-preferred Drug – Additional Required Information

What is the patient's current liver disease status?		
Decompensated liver disease (Child-Pugh score 5-10 and MELD ≤ 20)?	Yes	No
Post solid organ transplant, awaiting liver transplant, stage I-III hepatocellular carcinoma meeting Milan criteria?	Yes	No
Abdominal imaging findings suggestive of cirrhosis (for example, nodules, enlarged liver, tortuous hepatic arteries, ascites or portal hypertension)?	Yes	No
Results of non-invasive test: (list test completed and result)	TEST	RESULT
APRI > 1.5 FibroSURE > 0.49 Fibroscan > 7.1 kPa Fibrosis-4 index (FIB-4) > 3.25 MR Elastography > 6 kPa Fibrospect > 42		
Liver Biopsy > F3	Yes	No
OTHER RELEVANT PRESCRIBER CASE NOTES		

By signing, I verify that the information provided in this authorization request is complete and accurate. I further certify that I will provide the Department with outcomes of treatment (SVR12) in a timely fashion for each recipient I treat.

PRESCRIBER NAME	PRESCRIBER SIGNATURE	DATE
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Hepatitis C Outcome (Note the results below and fax to 651-431-7426)

RESULTS	DATE
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