

Montana Healthcare Programs Prior Authorization Request for Hepatitis C Treatment

Member's Name:	Member ID#:
Member's DOB:	Today's Date:
Provider's Name:	Provider NPI#:
Provider's Phone #:	Provider's Fax #:
Regimen Requested (Mavyret® preferred):	

I. ATTESTATIONS

Provider, please attest to the following:

- I have discussed the medication and treatment plan with the member, including:
 - Necessity of adherence and follow-up
 - Expected outcome and duration of treatment
 - Possible side effects
 - Monitoring requirements
- I have performed a psychosocial readiness evaluation for this member and have worked with the member to identify and eliminate barriers to successful treatment. Psychosocial readiness evaluations should include but are not limited to:
 - Assessment of motivation
 - Social support and stability
 - Medication adherence
 - Alcohol and substance use
 - Psychiatric stability
- I have evaluated the member's treatment regimen for possible drug interactions and have made any necessary adjustments.
- I will continue to engage with member throughout treatment and follow-up.
- Quantitative HCV-RNA testing has been performed to document active HCV infection.
- HCV-RNA viral quantification will be drawn 12 weeks post HCV treatment completion (SVR12) to document treatment results.

Provider Signature: _____

Date: _____

Member, please attest to understanding of the following:

- I understand not taking my medication every day may result in treatment failure.
- I understand I must return to my provider 12 weeks after completing treatment for a lab test that will ensure treatment was successful. If I fail to return to my provider, I will not be eligible for retreatment.
- For some hepatitis C treatment regimens, there are currently no U.S. Food and Drug Administration (FDA)-approved retreatment options for individuals who fail hepatitis C treatment. I understand I may not be eligible for retreatment.

Member Signature: _____
(or guardian signature if member is a minor)

Date: _____

II. Provider to review and complete the following:

Mavyret® is Montana Healthcare Programs' preferred Hepatitis C treatment for most individuals, because it is appropriate for all genotypes and most stages of liver disease and may only require eight weeks of treatment.

✓ Check if applicable:

<input type="checkbox"/>	Treatment Naive
<input type="checkbox"/>	Liver Fibrosis Stage F0, F1, F2, F3 or F4 (cirrhosis-compensated) See Liver Assessment Tool below to calculate compensated vs. decompensated status.
If both checked, Mavyret® x 8 weeks will be approved. If member does not meet both criteria, or if Mavyret® is not appropriate (e.g., drug interactions), please complete section III below.	

If member is less than 12 years old, please also provide member's age and weight:

Member's age: _____ Member's weight: _____ kg

Recommended Dosage in Pediatric Patients 3 Years of Age and Older (per Mavyret® package insert)

Body Weight (kg) or Age (yrs)	Daily Dose of Glecaprevir/pibrentasvir	Dosing of Mavyret®
Less than 20kg	150mg/60mg per day	Three 50mg/20mg packets of oral pellets once daily
20kg to less than 30kg	200mg/80mg per day	Four 50mg/20mg packets of oral pellets once daily
30kg to less than 45kg	250mg/100mg per day	Five 50mg/20mg packets of oral pellets once daily
45kg and greater OR 12 years of age and older	300mg/120mg per day	Three 100mg/40mg tablets once daily ¹ (Adult dosing)

¹ Pediatric patients weighing 45 kg and greater who are unable to swallow tablets may take six 50mg/20mg packets of oral pellets once daily. Dosing with oral pellets has not been studied for pediatric patients weighing greater than 45 kg.

III. Only complete the following if the above criteria are not met:

1. Treatment experience:

☐ Treatment naive

☐ Treatment experienced (please indicate regimen[s]): _____

2. Liver fibrosis stage:

☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4-Compensated (Child Pugh A) ☐ F4-Decompensated (Child Pugh B or C)

3. HCV genotype: _____

4. Requested drug regimen and treatment duration: _____

5. Provide rationale supporting use of alternative non-preferred drug: _____

LIVER ASSESSMENT TOOL

If **F4** (cirrhotic), determine compensated (Child Pugh A) vs. decompensated (B,C):

Assessment Parameter	Possible Points			Points Assigned
	1	2	3	
1. Ascites	Absent	Slight	Moderate	
2. Bilirubin, total (mg/dL)	1.0-2.0	2.0-3.0	>3.0	
3. Albumin (g/dL)	>3.5	2.8-3.5	<2.8	
4. Prothrombin Time - Seconds prolonged OR - International normalized ratio (INR)	1.0-4.0 <1.7	4.0-6.0 1.7-2.3	>6.0 >2.3	
5. Encephalopathy Grade 0 - no abnormality detected 1 - shortened attention span, impaired addition and subtraction skills, mild euphoria/anxiety 2 - Lethargy, apathy, disoriented to time, personality change, inappropriate behavior 3 - Somnolence, semi-stupor, responsive to stimuli, confused when awake, gross disorientation 4 - Coma, little or no response to stimuli, mental state not testable	None	Grade 1-2	Grade 3-4	
Total				

Adapted from: Pugh RN, Murray-Lyon IM, Dawson JL, Pietroni MC, Williams R. Transection of the oesophagus for bleeding oesophageal varices. Br J Surg. 1973 Aug;60(8):646-9. PMID.

Child Pugh Grade (as determined from total points):

Child Pugh A (Mild; **Compensated cirrhosis** = 5-6)

Child Pugh B (Moderate; Significant functional compromise; **Decompensated cirrhosis** = 7-9)

Child Pugh C (Severe; **Decompensated cirrhosis** = 10-15)

Please complete form and fax to Drug Prior Authorization Unit at 1-800-294-1350.