Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health

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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:

1. 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
2. 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
3. I have evaluated the member's treatment regimen for possible drug interactions and have made any necessary adjustments.
4. I will test for current or prior HBV infection before initiation of HCV treatment. If HCV/HBV coinfected, I will monitor for HBV reactivation and hepatitis flare during HCV treatment and post-treatment follow-up.
5. I will continue to engage with member throughout treatment and follow-up.
6. Quantitative HCV-RNA testing has been performed to document active HCV infection.
7. 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:

1. I understand not taking my medication every day may result in treatment failure.
2. 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 re-treatment.
3. 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: _____ **Date:** _____
(or guardian signature if member is a minor)

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, most stages of liver disease and may only require eight weeks of treatment.

✓ Check if applicable:

	Treatment Naive
	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 Mavyret® is not appropriate (e.g., drug interactions), please complete section III below.	

If member is less than 12 years old, please 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 Mavryet® 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 50 mg/20 mg packets of oral pellets once daily. Dosing with oral pellets has not been studied for pediatric patients weighing greater than 45 kg

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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.

08/2022