State of New Mexico
Medical Assistance Program Manual

Supplement

HUMAN SERVICES DEPARTMENT

DATE: April 17, 2018 **NUMBER: 18-04**

TO: ALL PRACTITIONERS PARTICIPATING IN THE NEW MEXICO MEDICAID PROGRAM

FROM: NSL NANCY SMITH-LESLIE, DIRECTOR, MEDICAL ASSISTANCE DIVISION

SUBJECT: NOTICE OF NEW HEPATITIS C VIRUS (HCV) TREATMENT REQUIREMENTS FOR FEE-FOR-SERVICE (FFS) MEDICAID RECIPIENTS

ATTACHMENTS: MAD 635 – "Drug Prior Authorization Form" and MAD 634 – "Uniform New Mexico HCV Checklist for Centennial Care"

The New Mexico Human Services Department (HSD) Medical Assistance Division (MAD) has implemented new requirements for FFS members with Chronic Hepatitis C Infection (HCV).

Effective immediately, requested medication treatments for FFS members with HCV will require approval based on the following guidelines:

1. Prescribers will be required to submit all treatment requests using the MAD 635 – "Drug Prior Authorization Form" and the MAD 634 - "Uniform New Mexico HCV Checklist for Centennial Care" (attached).

2. Requests regarding off-label, experimental, and other forms of treatment that are not specified in the guidelines:
    a. will require a peer to peer consultation with the requesting physician to further understand the request and its rationale; and
    b. the case will be presented to Project ECHO before issuing a denial.

3. Note that a "properly requested treatment" as defined above means that:
    a. The checklist form is completed fully as directed and submitted;
    b. Necessary lab data and copies of medical records are attached; and
    c. The requested drug(s), dose(s), and length of treatment are consistent with AASLD/IDSA guidance as written (the level of evidence in the guidance should not be considered relevant to length of treatment decisions).

The forms can be located at the Medicaid portal: https://nmmedicaid.portal.conduent.com

If you have questions regarding the above information, you may contact the Medical Assistance Division Centennial Care Contracts Bureau at (505) 827-3174.

Uniform New Mexico HCV Checklist

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PATIENT NAME: _____ **DOB:** _____

1. **DIAGNOSIS:** ☐ **Chronic Hepatitis C Infection, Genotype** ____ **Subtype** (if applicable)___ **(attach results), HCV RNA Level within the past 6 months: Level:**_____ **Date:**____/_____/____**(attach results)**

2. **ADDITIONAL REQUIRED LABS (within 3 months of request- please attach results)**

   ☐ AST, ☐ ALT, ☐ Bilirubin, ☐ Albumin, ☐ INR, ☐ Platelet count, ☐ Hemoglobin, ☐ Creatinine.
   Also document ☐ HBsAg, ☐ anti-HBs, ☐ anti-HBc

3. **LIVER ASSESSMENT:** There are seven stages of liver changes in chronic HCV infection – no liver fibrosis (F0), increasing levels of fibrotic change (F1, F2 and F3), cirrhosis (F4), decompensated cirrhosis and hepatocellular carcinoma.

   a. **FIBROSIS/CIRRHOSIS ASSESSMENT:** (provide information using at least one of the following methods)

   Indirect markers:

   APRI _____ $\text{APRI} = \dfrac{\dfrac{\text{AST Level}}{\text{AST Upper Limit of Normal}}}{\text{Platelet Count } (10^9/\text{L})} \times 100$

   FIB-4 _____ $\text{FIB-4} = \dfrac{\text{Age (years)} \times \text{AST (U/L)}}{\text{Platelet Count } (10^9/\text{L}) \times \sqrt{\text{ALT (U/L)}}}$

   Imaging Study: Method Used: _____ **Attach results**

   b. Does the patient have history, physical exam, laboratory, or radiographic imaging consistent with **decompensated cirrhosis** (i.e. ascites, encephalopathy, bleeding varices, etc.)?
   No ☐ **Yes** ☐ (attach relevant results and notes)

   Child-Pugh Score (circle one): Class A (CTP 5-6) B (CTP 7-9) C (CTP 10-15) *See table on page 2 for calculation method*
   If patient has decompensated liver disease (Child-Pugh B or C), it is recommended that treatment be co-managed with a gastroenterologist, infectious disease specialist or hepatologist, and that referral for transplant be strongly considered.

4. **LIVER TRANSPLANT No** ☐ **Yes** ☐ (If yes, check one): ☐ Transplant date_____ ☐ Being considered for transplant

5. Is patient **TREATMENT EXPERIENCED**? **No** ☐ If no, go to 6. **Yes** ☐ If yes, complete a – c below. If treatment experienced with Direct Acting Antivirals (DAA), also complete question d.

   a. List regimen(s) patient has received in past including year and duration of therapy:
   _____

   b. Did patient complete treatment regimen(s)? Unknown ☐ **Yes** ☐ **No** ☐ If "No," reason for discontinuation:
   _____

   c. What was patient's response to therapy? ☐ Unknown ☐ Relapse (post treatment SVR, then elevated HCV RNA level some time later) ☐ Non-response (HCV RNA remained detectable after complete treatment course)

   d. Have you reviewed the case with Project ECHO? **Yes** ☐ **No** ☐ If no, health plan may require Project ECHO consultation.

6. **RESISTANCE TESTING** (please attach results, if applicable)
   Does patient have genotype 1a and Zepatier will be prescribed? **No** ☐ **Yes** ☐ If yes, order ☐ NS5A

7. **REQUESTED MEDICATION(S)**

Drug:_____ **Dose:** _____ **Duration:** _____ **weeks**

Drug:_____ **Dose:** _____ **Duration:** _____ **weeks**

☐ **I am agreeable to approval and use of alternative drug(s), dose(s) and/or duration(s) based on current AASLD/IDSA guidance. Please have health plan contact me with recommendations.**

Comments: _____

NOTE: If you are submitting a request for treatment that is not recommended in the AASLD/IDSA guidance, please submit supporting medical literature.

8. **ADHERENCE POTENTIAL** ☐ **I attest my belief that this patient is capable of full adherence to the above treatment**

SEE ADDITIONAL RECOMMENDATIONS ON PAGE 2

9. Important Additional Recommendations:

(1) If patient has alcohol or illicit drug abuse history, please refer patient to addiction specialist for counseling and treatment

(2) HIV and Hepatitis A screening including HAV Ab should be performed.

(3) Hepatitis A and Hepatitis B vaccination series should be initiated if not already completed (and patient non-immune).

(4) Patients being considered for retreatment after failure of initial treatment with all-oral therapy should be considered for presentation to Project ECHO (attach notes).

Child-Turcotte-Pugh Classification for Severity of Cirrhosis

Clinical and Lab Criterias	Points*		
	1	2	3
Encephalopathy	None	Mild to moderate (grade 1 or 2)	Severe (grade 3 or 4)
Ascites	None	Mild to moderate (diuretic responsive)	Severe (diuretic refractory)
Bilirubin (mg/dL)	< 2	2-3	>3
Albumin (g/dL)	> 3.5	2.8-3.5	<2.8
Prothrombin time Seconds prolonged International normalized ratio	 <4 <1.7	 4-6 1.7-2.3	 >6 >2.3

***Child-Turcotte-Pugh Class obtained by adding score for each parameter (total points)**
Class A = 5 to 6 points (least severe liver disease)
Class B = 7 to 9 points (moderately severe liver disease)
Class C = 10 to 15 points (most severe liver disease)

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Drug Authorization Request Form

(1)* Insurer:	(2)* Date:

Member Information

(3) Group#:	(4) Member#:	(5) Name of Insured:

(6)* Patient Name, Last:	(7)* First:	(8) Initial:	(9)* DOB (mm/dd/yyyy):

(10)* Patient Address:	(11)* City:	(12)* State:	(13) Zip Code:	(14) E-mail:

(15) Primary Ph#:	Mobile #:	Work#:	(16)Height:	(17) Weight:	(18)* Gender
( )	( )	( )			M ☐ F ☐

(19) BIN#:	(20) PCN#:	(21) Issuer#:	(22) Employer Name:

Prescriber Information

(23) NPI#:	(24) DEA/XM#:	(25) * Specialty:	(26) Group practice or Organization:

(27) * Prescriber Name, First Last, and Title:	(28) Prescriber E-mail:	(29) Contact Name (Last, First):

(30) * Prescriber Address:	(31) * City:	(32) State:	(33) Zip Code:	⇨
(34) * Ph# & Ext.: ( )	(35) Fax#: ( )			(36) * Prescriber Signature:

Requested Medication

(37) * Diagnoses:	(38) Pending Discharge: Yes ☐ No ☐

(39)* Drug or Item:	(40) J-Code:	(41)* Strength:	(42) Directions:	(43)* Qty.:	(44)* Days Supply:	(45)* Refills:

(46) * Reason for request/ Justification (e.g. other medications tried/ lab values. etc.):	Anticipated Duration of Treatment: (48) Start Date:	(49) End Date:

Pharmacy/ Facility Information

(50) Pharmacy NPI#:	(51) * Pharmacy Address:

(52)* Pharmacy Name:	(53) * Fax#: ( )	(54) * Phone# & ext.: ( )

* *Indicates information is required. Failure to provide sufficient information will result in a denial.*

The Drug Authorization Request Form may be downloaded from an insurer's website.

The request may originate from the prescriber or from the pharmacy. If originating at the pharmacy, the pharmacy must transmit the form to the prescriber for the justification, medical information, and the prescriber's or authorized representative's signature.

Blocks 1 and 2: **Insurer Information**

Provide the name of the insurer and the date of the request. Follow the instructions on the insurer's website for submission of the form for authorization. Note that the form may need to be submitted to a pharmacy benefits manager rather than directly to the insurer.

Blocks 3, 4, and 5: **Coverage Information**

Supply the information necessary to identify the insured member and the insured's policy following the instructions on the insurer's website.

Blocks 6 through 13, and 16 through 22: **Patient Information**

Provide the information as requested on the form. The blocks with an (*) are required.

Blocks 14 and 15: **Patient Contact Information**

While not required, this information may help a pharmacy contact the patient (or the insured, parent, or guardian if a minor) regarding the status of the prescription.

Blocks 23 through 36: **Prescriber Information**

At a minimum, provide the information for the blocks that have an (*).

Block 26: Identify the group practice, clinic, or other entity with whom the prescriber is associated.

Block 29: Identify an individual within the office who may be efficiently contacted if there are questions regarding the request.

Block 36: The request must be signed by the prescribing practitioner or an authorized representative of the prescriber.

Blocks 37 through 49: **Requested Medication**

Provide sufficient information to identify the medication, the dosage and anticipated duration of treatment, etc.

Block 40: "J-codes" are primarily used by prescriber administered or prescriber dispensed drug items. The "J-codes" are found in the HCPC level II coding manuals, and often, but not always, begin with a "J". If not applicable, leave blank.

Block 46: Supply information that is reasonably necessary for approval of the drug or item. Insufficient information slows the process and requires additional contacts with the prescriber before the request can be approved.

Blocks 50 through 54: **Pharmacy or Other Dispensing Entity Information**

While not essential to complete this section, it is often efficient for the patient and all others to allow the insurer to work directly with the pharmacy or other facility to arrange for the dispensing. Sufficient information is necessary to assure the authorization is communicated to the correct dispensing pharmacy or other entity. Many pharmacies have the same name, so additional information is always required.