State of New Mexico

Medical Assistance Program Manual

Supplement

Effective 8/30/2021, requested medication treatments for Blue Cross Community Centennial 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 revised MAD 634 -"Uniform New Mexico HCV Checklist" for Centennial Care (attached).

2. Properly requested treatment will include:
    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).

3. Requests regarding off-label, experimental, and other forms of treatment that are not specified in the guidelines:
    a. FFS requesting physicians will present the case to Project ECHO before submitting the request;
    b. MCOs will require a peer to peer consultation with the requesting physician to further understand the request and its rationale; and
    c. If MCOs disagree with the requesting physician, MCOs will present the case to Project ECHO before issuing a denial.

The forms can be located on the HSD website in the “Providers” section, under the “Managed Care” vertical tab: https://www.hsd.state.nm.us/providers/Default.aspx

If you have questions regarding the above information, you may contact, Prime Therapeutics Contact Center at 888.840.3044.

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Uniform New Mexico HCV Checklist

PATIENT NAME: _____ **DOB:** _____

1. **DIAGNOSIS:** ☐ Chronic Hepatitis C Infection, Genotype ____ **(attach results)** or ☐ pending

   HCV RNA Level (any time prior to starting antiviral therapy): Level:_____ Date:____/_____/____(attach results)

2. **ADDITIONAL REQUIRED LABS (within 6 months of request- please attach results)**

   ☐ AST, ☐ ALT, ☐ Bilirubin, ☐ Albumin, ☐ Platelet count, ☐ Hemoglobin, ☐ Creatinine

3. **Documentation of (no time frame specified):**

   ☐ HBsAg, ☐ anti-HBs, ☐ anti-HBc (IgG or total) ☐ anti-HAV (IgG or total), ☐ HIV screen

4. **LIVER ASSESSMENT:**

   a. **FIBROSIS/CIRRHOSIS ASSESSMENT:**
   ☐ Non-cirrhotic ☐ Cirrhotic (if cirrhotic, complete sections b and c below) ☐ HCC (hepatocellular carcinoma)

   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)

   c. **For patients with cirrhosis:**
   REQUIRED LAB (within 6 months of request-please attach results)
   ☐ INR
   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) or HCC, it is recommended that treatment be co-managed with a specialist and that referral for transplant be strongly considered.

5. **HCC (hepatocellular carcinoma)?** ☐ **No** ☐ **Yes** If yes, patient should be managed with a specialist

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

7. Is patient **TREATMENT EXPERIENCED**? ☐ **No** If no, go to 8. ☐ **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 ☐ Non-response (HCV RNA remained detectable after complete treatment course) ☐ Reinfection (SVR followed by detectable HCV RNA **or** GT different than previously documented)

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

8. **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.

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

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

10. **Important Additional Recommendations:**

   (1) If patient has a current substance use disorder, consider referral to addiction specialist for counseling and treatment.
   (2) Hepatitis A and Hepatitis B vaccination series should be initiated if not already completed (and patient non-immune).

Uniform New Mexico HCV Checklist

(3) 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)

HUMAN SERVICES DEPARTMENT

Fax# (855) 212-8110

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:	(36) * Prescriber Signature (E-Signature acceptable)
(34) * Ph# & Ext.:	(35) Fax#:			

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.