Prior Authorization for Peg-interferon and Oral Ribavirin

Dear Provider,

Please review the instructions on the attached Peg-interferon & ribavirin prior authorization forms to complete and return to MADAP with the required lab reports. Completed requests will be reviewed upon arrival to determine if the client is eligible for MADAP coverage of these drugs. The MADAP fax number is 410-333-2608.

- The Initial MADAP Request form is required to determine eligibility for the first 12-week period of Hepatitis C treatment.
- The Continued MADAP Request form is required to determine eligibility for subsequent 12-week periods.
- **MADAP will pay for a course of treatment, or portion thereof, for a maximum of 48 weeks pending approval of the continuation requests.**

When authorization for Peg-interferon & ribavirin is requested with an HCV protease inhibitor or polymerase inhibitor for a triple-drug Hepatitis C regimen, the Supplemental Request form must be completed and submitted with the Initial or Continued request. **Please note that the MADAP formulary does not cover any of the HCV protease inhibitors or polymerase inhibitor.**

If a triple-drug regimen is prescribed, the following must be considered:

- The patient must be diagnosed with chronic HCV genotype 1 with confirmation of significant liver fibrosis.
- In the judgment of the clinician, it would be detrimental to the patient’s prognosis to delay prescribing a triple-drug regimen for Hepatitis C.
- The patient must be on an ART regimen that is not projected to interact with the triple-drug regimen or on no ART with a CD4 count >500.

Please keep in mind that the client must have active and ongoing MADAP eligibility for a minimum period of 12 weeks. A client approved for TAP is **not** eligible for MADAP coverage of Hepatitis C treatment.

You may contact me at 410-767-5262 if you need further assistance, additional forms or have any questions about the status of the submitted request.

Sincerely,

Arlette M Lindsay, PA
MADAP Clinical Advisor

Dated: 14Jan2014
CONTINUED MADAP COVERAGE OF PEGINTERFERON (ALFA 2A OR ALFA 2B) & RIBAVIRIN

CLIENT’S NAME: ___________________________ MADAP ID: 94 __ __ __ __ __ __ __ __

NOTE: This form must be completed for all clients whose treatment with the requested drugs has been ongoing for 90 or more days, regardless of payer. MADAP will pay for a course of treatment, or a portion thereof, not to exceed a 48-week period. The results of the RNA levels at 180 days/24 weeks will determine if MADAP will pay for treatment after 24 weeks. MADAP coverage begins the month of an approved request. MADAP coverage ends at 24 weeks (depending on RNA levels) or 48 weeks from the initiation of treatment. (See Supplemental Request for HCV RNA and coverage criteria with co-administration of telaprevir.)

1. Intend to continue peginterferon alfa 2a or 2b and oral ribavirin treatment?    □ No    □ Yes
   If the answer to question 1 is “No”, then treatment discontinuation is due to: (Please √ all that apply)
   □ Positive or detectable HCV RNA at 24 weeks of therapy  □ Myositis
   □ Intractable thrombocytopenia  □ Unusual side effect such as auto-immune
   □ Depression; not responsive to treatment  □ hypothyroidism
   □ Side effects of medical condition  □ Patient non-compliance or request
   □ Profound anemia or leukopenia; not responsive to  □ Other/Not listed, please describe:
   cytokine support

If the answer to question 1 is “Yes”, please continue with questions 2 – 8.

2. Requesting continuation of coverage for oral ribavirin and peginterferon:    □ alfa 2a or    □ alfa 2b

3. Date oral ribavirin and peginterferon treatment began/was resumed: _____/_____/_____

4. Treatment interval: (Please √ box that indicates how long it has been since treatment began.)
   □ 90 Days (12 weeks)*  □ 180 Days (24 weeks)**  □ 270 Days (36 weeks)

5. Patient was taking/will continue to take telaprevir:    □ No    □ Yes *If yes, skip to question #7 and complete Supplemental Request, section B.

6. If treatment has been ongoing for 180 Days/24 weeks or more, are HCV RNA levels at 24 weeks:
   □ Detectable?  or  □ Undetectable? (**Supporting laboratory reports must be submitted)

7. Treatment Side Effects: Please indicate (✓) the degree of discomfort due to peginterferon (alfa 2a or alfa 2b) & ribavirin treatment that is reported by the patient.
   1  2  3  4
   □ None  □ Minimal  □ Moderate  □ Severe

8. Is client continuing/resuming HIV treatment?    □ No    □ Yes

Prescribing Clinician: ___________________________ License No. & State: __________

Street Address: ___________________________ Phone #: __________

City, State & Zip: ___________________________ Fax #: __________

Clinician’s Signature: ___________________________ Date: _____/_____/_____

October 2011, revised
SUPPLEMENTAL REQUEST FOR MADAP COVERAGE OF PEGINTERFERON AND RIBAVIRIN

CLIENT’S NAME: ______________________________  MADAP ID: 94 __ __ __ __ __ __ __ __

Please select (✓) and complete section A or B and prescribing clinician’s information below.

☐ A. Initial use of Peginterferon and Oral Ribavirin with Telaprevir (INCIVEK)

NOTE: The prescribing clinician must complete this section and submit the signed form to MADAP for initial prior authorization of peg-interferon and oral ribavirin when a patient is being prescribed triple drug therapy with telaprevir (INCIVEK). MADAP does not cover telaprevir, but recommends the use of the appropriate patient assistance program for treatment coverage.

The patient must be diagnosed with chronic HCV genotype 1 with confirmation of significant liver fibrosis. In the judgment of the clinician, a delay in triple drug therapy would be detrimental to the patient’s prognosis. The patient must be on an ART regimen that is not projected to interact with telaprevir or on no ART with a CD4 count >500.

1. Patient is expected to take/is currently on telaprevir (Incivek):  □ No  □ Yes, start date: ___/___/___

2. If patient is not on antiretroviral therapy, please report the patient’s current CD4 count: _________/mm³

3. If patient is on antiretroviral therapy, please list the drugs being prescribed:

☐ B. Continuing use of Peginterferon and Oral Ribavirin with Telaprevir (INCIVEK)

NOTE: The prescribing clinician must complete this section and submit the signed form to MADAP for prior authorization of peg-interferon and oral ribavirin when a patient’s treatment with telaprevir and the requested drugs has been ongoing for 90 days, regardless of payer. The results of the HCV/RNA levels at 90 days/12 weeks on the triple drug therapy will determine if MADAP will pay for treatment after 12 weeks. MADAP coverage ends at 24 weeks (depending on RNA levels) or 48 weeks from the initiation of treatment.

1. Intend to continue telaprevir treatment?  □ No  □ Yes

If the answer to question 1 is “No”, then treatment discontinuation is due to: (Please ✓ all that apply)

☐ Telaprevir treatment course has been completed  ☐ Patient non-compliance or request
☐ Positive or detectable HCV RNA at 12 weeks of therapy  ☐ Other/Not listed, please describe:
☐ Side effect(s) associated with telaprevir:
  rash, anemia, fatigue, pruritus, nausea/vomiting

If the answer to question 1 is “Yes”, please continue with questions 2 – 4.

2. Date telaprevir treatment began: ___/___/___

3. If treatment has been ongoing for 90 Days/12 weeks, are HCV RNA levels at 12 weeks:

☐ Detectable?  or  ☐ Undetectable? (Supporting laboratory report must be submitted)

4. Is patient continuing/resuming HIV treatment?  □ No  □ Yes  If yes, list the ART being prescribed:

Prescribing Clinician: ______________________________  License No. & State: ______________________________

Street Address: ______________________________  Phone #: ______________________________

City, State & Zip: ______________________________  Fax #: ______________________________

Clinician’s Signature: ______________________________  Date: ___/___/___

October 2011, revised