Michigan Department of Health and Human Services (MDHHS)

Michigan Drug Assistance Program (MIDAP)

Hepatitis C/HIV Prior Authorization Request Form

The information on this form will be used in determining eligibility for the Michigan Drug Assistance Program's (MIDAP) HIV/HCV Treatment Assistance. A limited number of treatment slots are available (dependent upon available funding) for uninsured clients or whose insurance does not cover needed HCV medications. All questions must be completed, required documents much be attached, and the form must be signed by the client's medical provider applying for this assistance.

Criteria for enrollment in this program are:

- Provider compliance with the American Association for the Study of Liver Disease (AASLD) guidelines in the treatment of HIV/HCV coinfected patient http://www.hcvguidelines.org/full-report-view, and http://www.hcvguidelines.org/ https://www.hcvguidelines.org/unique-populations/hiv-hcv

Patient Information	
Last Name: ________________________	First Name: ________________________
MIDAP ID: ________________________ Social Security Number: ________________ Date of Birth: ______/______/_______ Gender: ☐ Male ☐ Female	Address: ________________________ City: ________________________ State: MI Zip: ______________ Phone Number: ____________________

Prescriber Information	
Last Name: ________________________	First Name: ________________________
NPI Number: ____________________ Phone Number: ____________________ Fax Number: ____________________	Address: ________________________ City: ________________________ State: MI Zip: ______________
Prescribers Specialty *(The prescriber must be a GI, ID specialist or a Hepatologist, otherwise collaboration/consultation is required).* **Indicate Specialty:** ☐ Gastroenterologist ☐ Hepatologist ☐ Infectious Disease Specialist **For providers not identified above:** If the prescribing provider is not one of the above listed specialists, it is expected the prescriber has collaborated / consulted with one of the above noted specialists. Please identify the specialty of the prescriber: ☐ Internal medicine ☐ Family medicine ☐ NP ☐ PA ☐ Other, Please Specify: ________________________________ Consulting/collaborating specialist name: ________________________________ In addition, please include supporting documentation that demonstrates consultation/collaboration with the specialist (e.g., consult notes, progress notes, plan of care, including dates noted)	

Pharmacy Information	
Name of Pharmacy: ____________________	
Phone Number: ____________________	Fax Number: ____________________

Clinical Criteria Documentation		
1. Does the patient have a diagnosis of HIV?	☐ Yes CD4 Count: ______ Viral Load: ______	☐ No
2. Has the patient had prior treatment for Chronic Hepatitis C? ☐ Yes ☐ No 2a. If yes, provide date(s) of treatment: ______________________ ______________________ 2b. Treatment regimen used: ____________________________________		
3. Check HCV Genotype: ☐ Genotype 1 ☐ Genotype 4 ☐ Genotype 1a ☐ Genotype 5 ☐ Genotype 1b ☐ Genotype 6 ☐ Genotype 2 ☐ Chronic Hepatitis C, mixed genotypes: ________ ________ ________ ☐ Genotype 3 ☐ Hepatocellular Carcinoma awaiting liver transplant ☐ without cirrhosis ☐ compensated cirrhosis body weight: ________ lbs.		
4. Does the patient have hepatocellular carcinoma?	☐ Yes	☐ No
5. Metavir Fibrosis Score **(attach documentation)** Date: ______________________	☐ Unknown ☐ F0 ☐ F1 ☐ F2	☐ F3 ☐ F4 ☐ F5 ☐ F6
6. Baseline HCV Viral Load **(attach documentation)**	Date: ______________________	
7. Hepatitis A Serology **(attach documentation)** 7a. HAV Results ☐ Positive ☐ Negative	8. Hepatitis B Serology **(attach documentation)** 8a. HBsAg Results ☐ Positive ☐ Reactive 8b. Anti-HBs or HBsAB Results ☐ Positive ☐ Reactive 8c. Anti-HBc or HBcAB Results ☐ Positive ☐ Reactive	
9. Child-Pugh Score	Points: ________	☐ A ☐ B ☐ C
10. PT/INR Values: __________	11. Bilirubin: _________	
12. What is the current (within the last 90 days) renal function (creatinine clearance or GFR, estimated)	________ mL/min	
13. Are the patients CBC **results attached** and within the last 90 days?	☐ Yes Date: _______________	☐ No
14. Are the patients AST/ALT **results attached** and within the last 90 days?	☐ Yes Date: ______________	☐ No
15. Is a recent (within 90 days) urine or blood test for illicit drugs and alcohol attached? **Results must be attached.**	☐ Yes	☐ No

15a. If positive results are present but are attributable to legally prescribed medications, please **attach the documentation** and explain the rationale for the positive results. 15b. If positive results are present but cannot be attributed to legally prescribed medications, please indicate whether the patient is actively attending or has been referred to a treatment program for substance abuse. This applies for any positive test results for alcohol, illicit substances, or prescription drugs for which the patient does not have a prescription. **(attach documentation)**	☐ Positive; attending treatment program ☐ Positive; referred to treatment program ☐ Positive; not attending/referred to treatment program	
16. Is a current list of all the patient's medications attached? **(attach documentation)** This list should include all scheduled maintenance and as needed (PRN) medications the patient will be taking while on HCV therapy.	☐ Yes	☐ No

Medication Selection: Indicate the genotype and treatment regimen being requested

EPCLUSA® (sofosbuvir/velpatasvir)			
Check genotype & treatment regimen	Patient Population	Treatment	Duration
	Genotype 1, 2, 3, 4, 5, or 6 without cirrhosis or with compensated cirrhosis	Epclusa®	12 weeks
http://www.gilead.com/~/media/files/pdfs/medicines/liver-disease/epclusa/epclusa_pi.pdf?la=en			

HARVONI® (ledipasvir/sofosbuvir)			
Check genotype & treatment regimen	Patient Population	Treatment	Duration
	Genotype 1: Treatment-naïve w/out cirrhosis who have pre-treatment HCV RNA less than 6mil IU/ml and HIV co-infected	Harvoni®	12 weeks
	Genotype 1: Treatment-naïve w/out cirrhosis or with compensated cirrhosis	Harvoni®	12 weeks
	Genotype 1: Treatment-experienced w/out cirrhosis	Harvoni®	12 weeks
	Genotype 1: Treatment-experienced with compensated cirrhosis	Harvoni®	24 weeks
	Genotype 4, 5, or 6: Treatment-naïve or treatment-experienced without cirrhosis or with compensated cirrhosis	Harvoni®	12 weeks
http://www.gilead.com/~/media/Files/pdfs/medicines/liver-disease/harvoni/harvoni_pi.pdf			

MAVYRET™ (glecaprevir/pibrentasvir)			
Check genotype & treatment regimen	Patient Population	Treatment	Duration
	Genotypes 1, 2, 3, 4, 5, or 6: without cirrhosis	Mavyret™	8 weeks
	Genotypes 1, 2, 3, 4, 5, or 6: with compensated cirrhosis	Mavyret™	12 weeks
http://www.rxabbvie.com/pdf/mavyret_pi.pdf			

ZEPATIER® (elbasvir/grazoprevir)			
Check genotype & treatment regimen	Patient Population	Treatment	Duration
	Genotype 1a: Treatment-naïve or peg-interferon/RBV experienced without baseline NS5A polymorphism	Zepatier®	12 weeks
	Genotype 4: Treatment-naïve	Zepatier®	12 weeks
http://www.merck.com/product/usa/pi_circulars/z/zepatier/zepatier_pi.pdf			

Submit Requests to:
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