Louisiana Health Access Program (LA HAP)
For Uninsured LA HAP Members and Medicaid/LA HAP Members
Prior Authorization for Hepatitis C Treatment Regimens

APPLICATION INFORMATION

Ramsell is the contracted PBM service provider for Louisiana Health Access Program (LA HAP). Requests for the prior authorization of Hepatitis C therapy will be reviewed for appropriateness of therapy by the Pharmacists in the Ramsell Clinical Department.

Please complete the attached supplemental form for Hepatitis C Treatment Regimens and fax to LA HAP at 504-568-3157. The request must include all of the supporting lab results and chart documentation for approval. For questions regarding services, call LA HAP at 504-568-7474.

FINANCIAL ELIGIBILITY

Patients must have current, non-temporary eligibility for the Louisiana Health Access Program for uninsured patients and LA HAP eligible Medicaid patients. They must maintain program coverage throughout the course of Hepatitis C treatment. If LA HAP has not confirmed eligibility, the application will be denied.

Approval Period: Authorization to receive Hepatitis C treatments are dependent upon the genotype, prior treatment regimens and/or a history of advanced liver disease (cirrhosis).

Limits: Treatment for Hepatitis C regimens are limited by program funding. Approval of this application is dependent on availability of LA HAP funding.

Approval notification: Clinicians will be notified of the approval decision via fax.

MEDICAL ELIGIBILITY

All supporting laboratory results and chart notes are **REQUIRED**:

- ☐ Baseline Complete Blood Count
- ☐ Hepatitis C Genotype
- ☐ Baseline Hepatitis C RNA viral load (within the last 3 months)
- ☐ CD4 count (within the last 6 months)
- ☐ HIV viral load (within the last 6 months)

If the patient has cirrhosis, please provide documentation to support the diagnosis of cirrhosis. Some examples include fibrosis staging, liver biopsy results and Child Pugh scoring:

- ☐ Fibrosis staging (METAVIR, FibroSure, etc)
- ☐ Liver biopsy results
- ☐ Child Pugh Score

Additional information: For the latest Hepatitis C treatment recommendations consult the American Association for the Study of Liver Diseases (AASLD)/Infectious Diseases Society of America (IDSA) Hepatitis C Treatment Guidelines at www.hcvguidelines.org.

Pharmacy Name	Pharmacy Address	City	State	Zip Code	Phone Number	Fax Number
OUR LADY OF THE ANGELS HOSPITAL PHARMACY	400 MEMPHIS STREET	BOGALUSA	LA	70427	985-730-7219	985-730-7220
LALLIE KEMP HOSPITAL[1]	52579 HWY 51 SOUTH	INDEPENDENCE	LA	70443	985-878-1317	985-878-1548
UNIVERSITY HOSPITAL & CLINICS OUTPATIENT PHARMACY[1]	2390 WEST CONGRESS ST	LAFAYETTE	LA	70506	337-266-4869	337-261-6263
MOSS MEMORIAL CLINIC PHARMACY	1000 WALTERS	LAKE CHARLES	LA	70607	337-480-8085	337-480-8216
UNIVERSITY HEALTH CONWAY[2]	4864 JACKSON ST., RM 1-161-B	MONROE	LA	71210	318-330-7143	318-330-7760
UNIVERSITY HEALTH SHREVEPORT[2]	1606 KINGS HIGHWAY	SHREVEPORT	LA	71103	318-813-1304	318-675-5181
AFFORDABLE PHARMACY	1718 N. FOSTER, SUITE B	BATON ROUGE	LA	70806	225-771-8134	225-771-8197
AVITA DRUGS #23	5551 CORPORATE BLVD, SUITE 102	BATON ROUGE	LA	70808	225-924-1930	225-924-2620
WINN DIXIE #1453	6800 GREENWELL SPRINGS RD	BATON ROUGE	LA	70814	225-216-9442	225-216-1751
WINN DIXIE #1577	13002 COURSEY BLVD.	BATON ROUGE	LA	70816	225-756-7110	225-756-7109
AVITA DRUGS #3*	219 SUNSET AVENUE, STE 118A	DALLAS	TX	75208	225-236-1540	225-924-3217
DOC-YOUR DOSE*	17275 HIGHWAY 77	GROSSE TETE	LA	70740	225-648-2329	225-648-2331
RELIANT HEALTHCARE*	1004 NORTH 19TH STREET	MONROE	LA	71201	318-322-8326	318-322-0998
AVITA DRUGS #1*	2601 TULANE AVE. STE. 445	NEW ORLEANS	LA	70119	504-822-8013	504-822-8141
RITE CARE PHARMACY*	3102 LINEWOOD AVE	SHREVEPORT	LA	71103	318-635-8159	318-631-7688

1 = Pharmacy only able to service patients of the facility's hospital clinics for LA HAP and LA HAP Medicaid

2 = Pharmacy only able to service patients of the facility's hospital clinics for LA HAP only

* = Pharmacy provides mail service

Louisiana Health Access Program (LA HAP) – Uninsured and Medicaid Patients
Supplemental Form for Hepatitis C Treatment Regimens
TELEPHONE LA HAP: 504-568-7474 FAX LA HAP: 504-568-3157

Please complete the appropriate sections below for determination of treatment authorization

☐ **Medicaid/LA HAP Member** ☐ **LA HAP member ONLY**

Patient Name_____ Prescribing Physician _____
Last Name First Name

Prescriber NPI # _____ Specialty _____

Member ID _____ Physician Phone # _____Fax#_____

DOB_____ Height _____Weight_____ Pharmacy Name# _____

CD4 count _____ HIV viral load _____ NABP# _____Contact Person_____

Baseline Hepatitis RNA: _____ Pharmacy Phone# _____Fax# _____

_____
Signature of pharmacist or physician Date

By signing above, you attest that all statements on this form are true to the best of your knowledge.

All supporting labs and chart documentation are REQUIRED for approval of this request.

Does this patient have diagnosis of Chronic Hepatitis C? ☐ Yes ☐ No

What is the Hepatitis C Genotype? (circle): 1a 1b 2 3 4 5 6

Serum marker of Fibrosis (FibroSure®): ☐ N/A ☐ F0 – F1(0.00-0.31) ☐ F1-F2 (0.31 – 0.58) ☐ F3-F4 (0.58 – 1.00)

Has this patient been treated for Hepatitis C previously? (check all that apply)

- ☐ None (Treatment naïve)
- ☐ Prior relapse to PEG/ribavirin Date:_____
- ☐ Prior partial responder to PEG/ribavirin Date:_____
- ☐ Prior null responder to PEG/ribavirin Date:_____
- ☐ Prior failure on telaprevir (Incivek®) or boceprevir (Vitrelis®) Date:_____

What is the planned treatment regimen and duration? (Please fill in):

- ☐ Drug Name(s) including strength :
  _____
- ☐ Daily Dosing: _____
- ☐ Duration of therapy (weeks):

Please confirm the following statements: (check all that apply)

- ☐ This patient is on a stable antiretroviral regimen for HIV with HIV viral load < 200 copies/mL
- ☐ This patient has failed multiple trials of antiretroviral therapy due to advanced liver disease precluding antiretroviral treatment prior to HCV treatment.

If the patient has advanced liver disease, please answer the following questions. (Circle)

Does this patient have a history of cirrhosis? YES☐ NO☐

Does this patient have decompensated liver disease☐YES NO☐

For All

- ☐ I agree to submit HCV RNA result from 4 (or 12) weeks after treatment completion for program evaluation purposes (FAX to Ramsell)
- ☐ I have reviewed the clinical information on the proposed prescription for possible drug-drug interactions with other medications currently prescribed to the patient

REQUIRED DOCUMENTATION - Please submit ALL required clinical notes/ lab reports in reference to this request. Failure to provide documentation will delay decision process.

☐ Hepatitis C Genotype ☐ Hepatitis C RNA viral load (within the last 3 months) ☐ CD4 count (within the last 6 months) ☐ HIV viral load (within the last 6 months) ☐ **As Needed**- Fibrosis staging results-FiborTest/FibroSure® (within the last 6 months)