

Allison Knight, Assistant Manager
DMAP Policy and Planning Section

Authorized Signature

Number: DMAP 06-217

Issue Date: 12/29/06

Topic: Medical Benefits

Subject: Provider announcements re: PA on Hepatitis C drug therapies

Applies to (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> All DHS employees | <input type="checkbox"/> County Mental Health Directors |
| <input type="checkbox"/> Area Agencies on Aging | <input type="checkbox"/> Health Services |
| <input type="checkbox"/> Children, Adults and Families | <input type="checkbox"/> Seniors and People with Disabilities |
| <input type="checkbox"/> County DD Program Managers | <input checked="" type="checkbox"/> Other (please specify): DHS staff and others identified on the SPD, CAF, OMHAS and OMAP transmittal lists |

Message: DMAP is posting the following two letters to prescribing providers and pharmacies respectively. They describe the January 2007 policy change regarding prior authorization of Hepatitis C drug therapies.

If you have any questions about this information, contact:

Contact(s):	Brian Olson, DMAP Pharmacy Program Manager		
Phone:	(503) 945-6492	Fax:	(503) 373-7689
E-mail:	brian.olson@state.or.us		



Oregon

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Division of Medical Assistance Programs
500 Summer Street NE, E35
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Voice (503) 945-5772
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TTY (503) 378-6791

December 29, 2006

To: Prescribing Providers

From: Allison Knight, Assistant Manager
DMAP Policy and Planning Section



Subject: PA for Hepatitis C drug therapies

Beginning January 3, 2007, DMAP will require prior authorization (PA) on new prescriptions for Hepatitis C drug therapies: peginterferon, ribavirin and ribavirin with peginterferon.

The only exception to this policy is for OHP clients who currently receive any of these therapies for Hepatitis C. They may renew their prescriptions without a PA.

We have attached a flow chart of approval criteria for your convenience.

These changes result from recommendations by the Drug Utilization Review (DUR) Board and are reflected in DMAP policy revisions for January (OAR 410-121-0040). The PA policy aligns with the National Institutes of Health *Consensus Development Conference Statement: Management of Hepatitis C 2002* and the Center for Disease Control's optimal treatment standards.

To Obtain PA: Call First Health at 1-800-344-9180 or fax requests to 1-800-250-6950 or 1-888-603-7696.

Questions? Contact DMAP Provider Services at dmap.providerservices@state.or.us or 1-800-336-6016.

Have you registered your NPI and taxonomy code(s) with DMAP yet? Access the form online at <http://dhsforms.hr.state.or.us/Forms/Served/OE1038.pdf>.

OMAP CU Dec 06-322

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HEPATITIS C THERAPY

(peginterferon alfa-2a, peginterferon alpha-2b, ribavirin, ribavirin with peginterferon alfa-2a and ribavirin with interferon alfa-2b))

Cover drugs only for those patients where there is medical evidence of effectiveness and safety.

INITIATIVE: MAP: Hepatitis C

Length of Authorization: 3, 4, 9 or 12 months

REQUIRES PA: All drugs in HIC3 = W5G

HSN	Brand	Generic	Form
004184	COPEGUS	RIBAVIRIN	TABLET
004184	REBETOL	RIBAVIRIN	CAPSULE, SOLUTION
004184	RIBAPAK	RIBAVIRIN	TAB DS PK
004184	RIBASPHERE	RIBAVIRIN	CAPSULE, TABLET
004184	RIBATAB	RIBAVIRIN	TABLET, TAB DS PK
004184	RIBAVIRIN	RIBAVIRIN	CAPSULE, TABLET
018438	REBETRON	RIBAVIRIN/INTERFERON A-2B	KIT
021367	PEG-INTRON	PEGINTERFERON ALFA-2B	KIT, PEN IJ KIT
024035	PEGASYS	PEGINTERFERON ALFA-2A	KIT, VIAL

Approval Criteria

What is diagnosis being treated? Document ICD9		
1. Is the request for continuation of therapy? Patient is currently (prior 12 weeks) on HCV treatment according to Rx profile)	Yes: Continue to #10.	No: Continue to # 2.
2. Does the patient have a history of previous interferon-ribavirin combination treatment? Verify by reviewing member's Rx profile for combination interferon-based hepatitis C drugs (Rebetron, PEG-Intron, Pegasys, interferon-alpha) history. Does not include interferon monotherapy.	Yes: Fwd to DMAP Medical Director.	No: Continue to #3.

<p>3. Does the patient have any of the following contraindications to the use of interferon-ribavirin therapy?</p> <ul style="list-style-type: none"> • Severe or uncontrolled psychiatric disorder • Decompensated cirrhosis or hepatic encephalopathy • Cytopenias • Untreated hyperthyroidism • Severe renal impairment or transplant • Autoimmune disease • Pregnancy • Unstable CVD. 	<p>Yes: DENY</p>	<p>No: Continue to #4.</p>
<p>4. Has the patient been abstinent from IV drug use or alcohol abuse for ≥ 6 months?</p>	<p>Yes Continue to #5.</p>	<p>No: DENY</p>
<p>5. Does the patient have a detectable HCV RNA (viral load) $> 50IU/mL$?</p>	<p>Yes: Continue to #6.</p>	<p>No: DENY</p>
<p>6. Does the patient have a documented HCV Genotype?</p>	<p>Yes: Continue to #7.</p>	<p>No: DENY</p>
<p>7. Are liver biopsy results available?</p>	<p>Yes: Continue to #8.</p>	<p>No: DENY</p>
<p>8. Does the biopsy report show evidence of fibrosis (stage >1) and inflammation (grade ≥ 2) OR necrosis?</p>	<p>Yes: Continue to #9</p>	<p>No: DENY</p>
<p>9. Approve for 16 weeks with the following response:</p>	<p>Your request for _____(drug) has been approved for an initial 16 weeks. Subsequent approval is dependent on documentation of response via a repeat viral load demonstrating undetectable or 2-log reduction in HCV viral load. Please order a repeat viral load after 12 weeks and phone or fax lab results to First Health for continuation therapy.</p>	
<p>10. Does the patient have <u>undetectable</u> HCV RNA or at least a 2-log reduction (\pm one standard deviation) in HCV RNA measured at 12 weeks?</p>	<p>Yes: Continue to #11</p>	<p>No: DENY</p>

<p>11. Approve as follows:</p>	<ul style="list-style-type: none"> • <u>For genotype 1 or 4</u>, approve for an additional 36 weeks or for up to a total of 48 weeks of therapy (whichever is the lesser of the two). Apply ribavirin quantity limit of 200 mg tablets QS# 180 / 25 days. • <u>For genotype 2 or 3</u>, approve for an additional 12 weeks or for up to a total of 24 weeks of therapy (whichever is the lesser of the two). Apply ribavirin quantity limit of 200 mg tab QS# 120 / 25 days. • <u>For all genotypes and HIV co-infection</u>, approve for an additional 36 weeks or for up to a total of 48 weeks of therapy (whichever is the lesser of the two). Apply ribavirin quantity limit of 200 mg tablets QS# 180 / 25 days. <p>*** Approval for beyond quantity and duration limits requires approval from the DMAP Medical Director.</p>	
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DATE(s)

DUR Board Action: 9-15-05, 11-30-04, 5-25-04,

Revision(s)

Initiated: 1/1/07



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December 29, 2006

To: Pharmacy Providers

From: Allison Knight, Assistant Manager
DMAP Policy and Planning Section



Subject: PA for Hepatitis C drug therapies

Beginning January 3, 2007, DMAP will require prior authorization (PA) on new prescriptions for Hepatitis C drug therapies: peginterferon, ribavirin and ribavirin with peginterferon. DMAP has notified all of our prescribing providers of this policy change.

The only exception to this policy is for OHP clients who currently receive any of these therapies for Hepatitis C. They may renew their prescriptions without a PA.

These changes result from recommendations by the Drug Utilization Review (DUR) Board and are reflected in DMAP policy revisions for January 2007 (OAR 410-121-0040). The PA policy aligns with the National Institutes of Health *Consensus Development Conference Statement: Management of Hepatitis C 2002* and the Center for Disease Control's optimal treatment standards.

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OMAP CU Dec 06-324

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