MedStar Family Choice

5233 King Ave., Ste. 400
Baltimore, MD 21237
P 800-905-1722
F 410-933-2274
MedStarFamilyChoice.com

To all practitioners and referral coordinators:

When submitting a request for authorization for MedStar Family Choice (MFC) Maryland HealthChoice members, please make sure you complete the Prior Authorization Request form in its **entirety**.

Prior Authorization forms are available on the MedStar Family Choice website for download. Go to **MedStarFamilyChoice.com**, select Healthcare Providers under the Maryland HealthChoice section, and then click on the Preauthorization and Utilization Management box.

A complete request must contain the following:

- All pertinent member demographics;
- Provider contact information;
- Dates of Service;
- Facility name and NPI# if procedure is being done in a facility;
- ICD10 diagnosis code;
- CPT(s) or HCPCS code(s); and
- Clinical information to support the request.

Please note: If the request is for a non-formulary medication, please include clinical information about whether the member has tried and failed formulary option(s) or why the formulary option(s) is not appropriate to use.

Requests cannot be processed without this information.

Request forms are included for your use.

Thank you,

MedStar Family Choice
Utilization Management Department
410-933-2200, option 2

MedStar Family Choice

Fax completed form to MFC at 888-243-1790 or 410-933-2274.
Medication to be supplied by Caremark Specialty Pharmacy after approval.

HEPATITIS C THERAPY PRIOR AUTHORIZATION FORM

Please attach copies of the patient's medical history summary, lab and genetic test reports to the State.
****Please review our clinical criteria before submitting this form. ****

Patient Information

Recipient:_____ MA#:

_____

Date of Birth: _____/_____/_____ Phone #: ( ) _____ - _____

Treatment

□ _____: sig: _____ for _____ weeks Disp: #_____
Medication name

□ _____: sig: _____ for _____ weeks Disp: #_____
Medication name

Adherence with prescribed therapy is a condition for payment of therapy for up to the allowed timeframe for each HCV genotype.

Has a treatment plan been developed and discussed with patient? □ No □ Yes

Does the patient have any history of medication non-adherence? □ No □ Yes; If yes, please explain below the details of non-adherence and how will it be addressed:

_____

Diagnosis

- **Please check all that apply:**

□ Chronic Hep C (must document 6 months of viremia or have statement in office note that member has had Hepatitis C for > 6 months)

□ Hepatocellular Carcinoma

□ Liver transplant recipient: Genotype of pre-transplant liver: _____ Genotype of post-transplant liver: _____

- **What is the patient's HCV genotype and subtype? _____**

- **Fibrosis testing:**

Test used: _____; Test date : ____/____/____ Metavir Grade: A_____ Metavir Stage: F_____
(Ex: Fibrosure, biopsy, Fibroscan)

- **What best describes this patient's liver disease?**

□ No cirrhosis □ Compensated cirrhosis Child-Pugh Classification: _____ □ Decompensated liver disease Child-Pugh Classification: _____

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Hepatitis C Treatment History

Has this patient been treated for Hepatitis C in the past: □ Treatment Naïve (skip to Laboratory Results section)
□ Treatment Experienced (complete this section fully)

Please indicate what prior regimen(s) the patient has been treated with:

HCV regimen	Genotype **BEFORE** treatment	Treatment duration/dates	Treatment Outcome	Genotype **AFTER** treatment
			□ Relapsed □ Partial Responder □ Non-Responder □ Toxicities □ Other:	
			□ Relapsed □ Partial Responder □ Non-Responder □ Toxicities □ Other: _____	

Laboratory Results

Baseline HCV RNA level (must be <90 days old): _____ Date:_____/_____/_____

For all regimens please attach AST, ALT, total bilirubin and albumin.

If a sofosbuvir-containing regimen is prescribed, please attach serum creatinine AND/OR eGFR.

If ribavirin is prescribed, please attach hemoglobin, hematocrit and platelet count.

Medical History

Is the patient co-infected with HIV?
□ No □ Yes; If yes, state the patient's HIV viral load? _____ Date drawn: _____/_____/_____
(must be < 6 months old)

Is the patient co-infected with hepatitis B?
□ No □ Yes; If yes, state the patient's hepatitis B viral load? _____ Date drawn: _____/_____/_____
(must be < 6 months old)

Has patient had a solid organ transplant?
□ No □ Yes; If yes, specify what type of transplant: _____ Date of transplant: _____/_____/_____

Substance Use History

Does the patient have an active diagnosis of a substance use disorder? □ Yes □ No

If Yes, is the patient actively engaged in treatment? □ Yes □ No;
If No, please indicate whether an adherence assessment has been done to assure successful treatment completion:
□Yes □No, Please provide detail assessment plan:

_____

_____

Most Recent Assessment

Date of most recent office visit: _____ (must be within 3 months).

If the patient's Medicaid eligibility changes during therapy and the patient is no longer eligible for Medicaid prescription drug assistance, is the physician prepared to enroll the patient in other patient assistant drug programs to complete therapy? □ Yes □ No

I certify that the information provided is accurate. Supporting documentation is available for State audits.

_____

Prescriber's signature Prescriber's Name Date

Telephone# (_____) – _____- _____ Fax# (_____) - _____ - _____

Practice Specialty: _____

Address: _____

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MedStar Family Choice Hep C Prescriber Checklist

☐ Office visit < 90 days old.

☐ Hep C viral load < 90 days old.

☐ AST/ALT, Total Bili, Albumin, GFR, CBC < 90 days old.

☐ If HIV+, HIV viral load < 90 days old, showing <200 copies/mL.

☐ If Hep B+, Hep B viral load < 90 days old.

☐ Hep C genotype lab.

☐ Fibrosure, Fibroscan, or liver biopsy result.

☐ Documentation that pt. has had CHRONIC hep C meaning hep C present for ≥ 6 months. Submit:

☐ lab studies showing 6 months of viremia.

-OR-

☐ statement in last office visit note of when member was diagnosed.

-OR-

☐ statement of estimation of when hepatitis C was acquired (these will be sent to MDH for review). An example of an acceptable statement is: *"Even though the patient first tested positive for hepatitis C on _____, I am certain he/she acquired the virus in _____ (year or timeframe of years) when he/she _____ (was actively using, got a tattoo, etc.). Therefore, the patient most certainly has chronic hepatitis C."*

☐ Treatment history documented in last office visit note, clearly stating a full hep C medication history or treatment naive.

☐ Complete social history. If pt. has a history of or currently has substance abuse disorder (ETOH included), please document that pt. is well enough to be compliant with hep C treatment regimen.

☐ Child-Pugh score for pts with cirrhosis.

Prior Authorization Medication Request

MedStar Family Choice

Date: _____

MFC - Maryland Fax: (410) 933-2274

☐ **Vacation** ☐ **Lost Medication** ☐ **MD Increased Dose/Frequency** ☐ **Medication Stolen**

☐ **Out of Medication**

Member Name: (*Please print*) _____DOB: _____

Member MedStar Family Choice ID #: _____ **Medicaid ID #:** _____
(*MFC ID begins with **91**…)*

Provider Name/Office: _____ **NPI#**_____

Provider Phone: _____ **Provider Fax:** _____

Contact Person Name: _____

Contact Phone w/ext: _____ **Contact Fax:** _____
(If different from above)

Medication Requested (*Dose and Frequency*):_____

****Is the member currently on this medication:** ☐ **Yes** ☐ **No**

Include Previous Medications: _____

Please consult the MedStar Family Choice formulary before submitting for prior authorization

Diagnosis Code(s) /ICD-10:_____

Pharmacy Name: _____ **Phone:** _____

****Please provide all clinical notes to support the request and fax to the number above***

☐ **Approved** ☐ **Denied** **MFC Reviewer:** _____

MedStar Family Choice

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INTERVENTIONAL PAIN MANAGEMENT PRIOR AUTHORIZATION FORM

Please attach copies of the patient's record.

****Please review our clinical criteria before submitting this form. ****

Patient Information

Patient Name:_____

MFC Member ID #: _____

Date of Birth: _____/_____/_____

Procedure Requested

Contact Person Name:_____

Contact Phone w/ext:_____ **Contact Fax:**_____

Date(s) of Service:_____

Facility name:_____

CPT Code(s) and Quantities Requested: _____

_____

ICD 10 Codes: _____

□ **Epidural Steroid Injection**:

Right side: vertebral location(s) requested_____

Left side: vertebral location(s) requested _____

□ **Facet Joint Injection**:

Right side: vertebral location(s) requested _____

Left side: vertebral location(s) requested_____

□ **Percutaneous Neuroablation**:

Right side: vertebral location(s) requested _____

Left side: vertebral location(s) requested_____

□ **Sacroiliac Joint Injection:**

Right or Left (circle one)

Diagnosis: □ cervical radiculopathy □ lumbar radiculopathy □ non-specific low back pain

□ cervical facet joint pain □ lumbar facet joint pain □ sacroiliac joint pain

□ other- specify:_____

Additional history:

Has the patient had a trial of **Activity Modification**? □ no □ yes - If yes, length of trial: _____weeks

Dates of Activity Modification: _____ to _____

Has the patient participated in **Physical Therapy**? □ no □ yes - If yes, length of therapy: _____weeks

Dates of Physical Therapy: _____ to _____

Physical Therapy location/office name:

_____

Please note: Physical Therapy notes must be submitted with this request

Injection history:

□ initial injection

□ repeat injection (please complete table below)

Date(s) of prior injection(s)	Type of Injection (epidural, facet, SI joint, ablation)	Vertebral location(s)	Side: Left, Right, or Bilateral	Percent pain relief	Duration of pain relief

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I certify that the information provided is accurate. Supporting documentation is available for audits.

Provider's signature _____

Provider's name _____

Provider NPI# _____

Date _____

Practice specialty: _____

Prior Authorization Request for Home Health Services

MedStar Family Choice

Date: _____

MFC - Maryland Fax: (410) 933-2274

Member Name: (*Please print*) _____**DOB:** _____

Member MedStar ID #: _____ **or Medicaid ID #:** _____
(*MD ID begins with **91**…*)

Home Health Agency: _____ **NPI#**_____

Ordering Physician_____ **Provider Phone**_____

Contact Person Name: _____

Contact Phone w/ext: _____ **Contact Fax:** _____

Date of 6th visit: _____

Date(s) of Service requested (date range): _____

# of visits: SN ____ **PT** ____ **OT** ____ **ST** ____

What is the skilled need? _____

Diagnosis Code(s)/ICD-10: _____

CPT/HCPCS Code for services being requested: _____

*****Please include all of the following documents that apply*****

- Most Recent SN, PT, OT or ST visit notes
- Wound measurements/assessment (current)
- Goals and plan to support need for additional visits
- Any New Physicians orders/wound care orders

Revised 5/21/19

Prior Authorization (Non-Pharmacy) Request

MedStar Family Choice

Date: _____

MFC - Maryland Fax: (410) 933-2274

Member Name: (*Please print*) _____**DOB:** _____

Member MedStar ID #: _____ **Medicaid ID #:** _____
(*MD ID begins with **91**…)*

Provider Name/Office: _____ **NPI#**_____

Provider Phone: _____ **Provider Fax:** _____

Contact Person Name: _____

Contact Phone w/ext: _____ **Contact Fax:** _____
(If different from above)

MUST CHECK ONE: **Inpatient** ☐ **Outpatient** ☐

Date(s) of Service: _____

Facility Name: _____**NPI#**_____

Diagnosis Code(s) /ICD-10:_____
CPT Code/HCPS: _____
_____**Units** _____

*****Please include all of the following documents that apply*****

- Clinical/Office Notes
- X-Rays/MRI/CT/PET Scan or other applicable radiology studies
- Lab results

☐ Approved ☐ Denied MFC Reviewer: _____