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Post Hepatitis C Treatment Information — Sustained Virologic Response (SVR) Reporting Prior Authorization of Benefits Form — addendum

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-664-7184
Provider Help Desk: 515-327-7012, ext. 47754

1. Patient information	**2. Physician information**
Patient name:_____	Prescribing physician:_____
Patient ID #: _____	Physician address: _____
Patient DOB:_____	Physician phone #: _____
Date of Rx: _____	Physician fax #:_____
Patient phone #:_____	Physician specialty:_____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____

7. Diagnosis:_____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization (PA) is required for hepatitis C treatments. PA criteria require the prescriber to submit viral load data 12 weeks after the completion of therapy (SVR12).

Post-treatment viral load (attach results):

Date obtained:

Did patient achieve cure? ☐ Yes ☐ No
If no, provide reasoning for failure to achieve cure:

Did patient experience any adverse events during treatment? ☐ Yes ☐ No
If no, provide a description of adverse events experienced by the patient:

Patient name: _____ Patient ID #: _____

Rationale for not obtaining required data or anticipated date of completion:

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete, and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.