Antiviral Agents for Hepatitis C Virus

Medicaid prior authorization | refill request

This form is only for traditional Medicaid patients. Please complete all fields and **fax to 1-844-474-3341** for hepatitis C virus (HCV) treatment refills. Initial prior authorization (PA) requests should be completed using the *Prior Authorization Initial Request Form*. **PA must be requested every six weeks for therapy continuation.** Labs are required for weeks 4 and 12 of therapy. Please review Section 3 for timelines. Failure to provide documentation of labs may result in PA denial.

1. Patient information

Name (Last, First):	Medicaid ID #:	Date of birth: (mm/dd/ccyy)
Gender: ☐ Male ☐ Female	Current weight: _____ ☐ lb ☐ kg	Therapy start date:

2. Prescriber information

Prescriber information (Accepted specialties include gastroenterology, hepatology, and infectious disease)		
Prescriber name:	NPI #:	State license #:
Phone:	Fax:	Prescriber specialty:

Consulting/supervising physician if applicable:	Name:	Phone:

3. Treatment information

a. Please indicate requested approval period:

☐ Weeks 6-12 **(week 4 labs due)** ☐ Weeks 13-18 ☐ Weeks 19-24 **(week 12 labs due)**

b. Is the patient compliant with HCV treatment? ☐ Yes ☐ No

c. Professional judgment should be used by the prescriber to determine if alcohol or drug tests are needed.

d. In the table below, specify all drug(s) being requested in the hepatitis C regimen and indicate the total duration of the drug regimen in weeks.

Requested drug name(s)	Duration of drug regimen (weeks)
1.	
2.	
3.	

4. Laboratory*

Laboratory test	Value	Date	Critical values
ALT			> 10 x ULN (400 U/L)
SCr			> 2 mg/dl
CrCl			< 30 ml/min/1.73m^2
Hgb			< 8.5 g/dl
WBC			< 1,000 cells/µL
ANC			< 500 cells/µL
Plt			< 25,000 cells/µL
HCV RNA level week 4			
HCV RNA level week 12			

** In certain cases, additional labs may be requested.*

5. Signature

Provider signature:_____ Date: _____

*Provider signature indicates provider attests to all information outlined in the **Antiviral Agents for Hepatitis C Virus Prior Authorization Form, Prior Authorization Criteria and Policy,** and **Patient Education for Hepatitis C Treatment Prescriber Certification** documents.*