HEPATITIS C THERAPY PRIOR AUTHORIZATION FORM

Incomplete forms will be returned

Maryland Medicaid Pharmacy Program

Phone: 800-310-6826 Fax: 866-940-7328

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 #: ( ) _____ - _____ Body Weight: _____ kg

Treatment

□ _____: Take _____daily for _____ weeks

□ _____: Take _____daily for _____ weeks

□ _____: Take _____daily for _____ weeks

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

Diagnosis

□ Acute Hep C

□ Chronic Hep C (Hep C present for ≥ 6 months) as established by (please select one)

- □ Lab testing such as an HCV antibody or HCV RNA test completed 6 months apart
- □ HCV diagnosis documented in prescribers note from the past office visit(s)
- □ Exposure risk history documented in prescribers notes from the past office visit(s)

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

Genotype of post-transplant liver: _____

□ Other:_____

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

Has a liver biopsy been performed? □ No □ Yes; Test date : _____/_____/_____

Has a fibrosis test been performed: □ No

□ Yes; Test used: _____; Test date : _____/_____/_____

Metavir Grade: _____; Metavir Stage: _____

What best describes this patient's liver disease? (Check all that apply):

□ No cirrhosis □ Compensated cirrhosis □ Decompensated liver disease

****Please provide a copy of the results of the biopsy, genotype and any other fibrosis tests for this patient. ****

Hepatitis C Treatment History

Has this patient been treated for Hepatitis C in the past: □ Treatment Naive □ Treatment Experienced

If Treatment Experienced, what was the outcome of the previous treatments:

□ Relapsed □ Partial Responder □ Non-Responder □ Toxicities □ Reinfection

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

HCV regimen	Treatment duration/ dates	Treatment Outcome
		□ Relapsed □ Partial Responder □ Non-Responder □ Toxicities □ Reinfection □ Other:
		□ Relapsed □ Partial Responder □ Non-Responder □ Toxicities □ Reinfection □Other:_____

Laboratory Results

Baseline HCV RNA level (up to and including 180* days prior to treatment): _____

Date:_____/_____/_____

*unless the patient is cirrhotic then the baseline lab values must be within 90 days of prior authorization request

For cirrhotic patient, please attach total bilirubin, albumin, and INR.

If a regimen is prescribed containing ribavirin, 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: _____

Is the patient co-infected with HBV? □ No □ Yes; If yes, state the patient's HBV viral load? _____
Date drawn: _____

Is the patient co-infected with other viral infection: _____

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

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

Contact Person at your office: (name):_____Telephone #:_____

I certify that the benefits of the treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge. MDH and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.

_____

Prescriber's signature Prescriber's Name Date

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

Practice Specialty: _____