

HEPATITIS C THERAPY PRIOR-AUTHORIZATION FORM

Incomplete form will be returned

Please attach copies of the patient 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: ____/____/____ Body Weight: _____ kg

Phone #: () _____ - _____

Patient location: Home Hospital Clinic

Diagnosis (Attach genotype test results)

Acute Hep C Chronic Hep C Genotype of pre-transplant liver: _____
 Hepatocellular Carcinoma
 Genotype of post-transplant liver: _____ other: _____

What is patient's HCV genotype (including subtype)? _____

Has a liver biopsy been performed? Yes No Test date : ____/____/____

Provide a copy of biopsy results or other fibrosis test, specify Metavir grade: _____ stage: _____

Hepatitis C Patient Characteristics

This request is for: New Therapy Relapser Partial Responder Non-Responder

Compensated cirrhosis (treatment naïve or experienced) No cirrhosis Decompensated liver d/s

Drug Regimen with Strengths/Dosages/Length of Therapy and Treatment Plan

Sovaldi®: _____ Olysio™: _____

Pegylated interferon: _____ Ribavirin: _____

Harvoni®: _____ Other: _____

Anticipated total treatment duration: _____

(Adherence with prescribed therapy is a condition for payment for continuation therapy for up to the allowed timeframe for each HCV genotype. The recipient's Medicaid drug history will be reviewed prior to approval.)

Has drug therapy treatment plan been developed and discussed with patient Yes No

Any issues with drug adherence? Yes Explain: _____ No

Adherence assessment: _____

Laboratory Results

Has a test been performed for the Q80K polymorphism (for Olysio™ only)? Yes No Test date: ____/____/____

Baseline HCV RNA level (within 60 days pre-treatment): _____ log10_____ Date: ____/____/____

Date of HCV RNA rebound (≥ 1 log10 increase from the nadir HCV RNA) any time while on treatment: ____/____/____

Liver enzyme levels: Baseline ALT/AST: _____ Date measured: ____/____/____

Baseline platelet: _____ Date measured: ____/____/____

Baseline hemoglobin/hematocrit: _____ Date measured: ____/____/____

Medical History

Does patient have HIV/HCV co-infection? Yes No

Has patient had a solid organ transplant? Yes No Specify transplant date: ____/____/____

Does the patient have a history of any of the following:

- anemia autoimmune hepatitis or other autoimmune conditions pregnant renal d/s thrombocytopenia
- severe concurrent medical d/s (i.e. AIDS, cancer, significant CAD) hemoglobinopathies (i.e. sickle cell, thalassemia)
- currently on didanosine unstable CVD

Does patient have history of depression or mood disorder? Yes No

If yes, is patient stable on current medication? Yes No

Does patient have history of Drug/Alcohol Abuse? Yes No If yes, is patient abstinent for last 6 months? Yes No

If no, is patient currently in drug rehabilitation program? Yes No

Prior Drug Utilization

List concomitant drugs that might interact with any of the prescribed Hep C drugs: _____

List all previous hepatitis C therapies including adverse effects associated with prior therapy and reason for drug failure. If the patient is contraindicated or ineligible to receive a portion of a therapy (interferon), please provide a reason: _____

If patient's Medicaid eligibility change during therapy and 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: ____/____/____

Practice Specialty: _____

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

Address: _____

- Medications will be dispensed through Caremark Specialty Pharmacy
- Initial authorizations will be for 8 weeks per the DHMH guidelines to the Medicaid MCOs
- HCV RNA level obtained between treatment week 2 and week 4 will be **REQUIRED** for continued authorization of medication after 8 weeks
- A copy of the **HEPATITIS C THERAPY CONTINUATION AUTHORIZATION FORM and PRESCRIPTION** will be sent to the prescriber's fax number provided above prior to the renewal date as a reminder