MedStar Family Choice

Caring For You. Caring About You.

MedStar Health

Fax completed form to MFC DC 202-243-5496

Medication to be supplied by Caremark Specialty Pharmacy after approval

HEPATITIS C THERAPY PRIOR AUTHORIZATION FORM

Incomplete forms will be returned

Please attach copies of all supporting documents:

biopsy reports, laboratory studies including fibrosis testing, genotype, office notes, etc.

Patient Information

Recipient:_______________________________ MA#: ____

Date of Birth: ________/________/________ Phone #: (   ) _______ - ________ Body Weight: ________ kg

Treatment Plan

□ Harvoni®: Take________ tablet(s) once daily for ________ weeks

□ Epclusa®: Take __________daily for ________ weeks

□ Other: ____

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:

____

____

Diagnosis

□ Chronic Hepatitis C (Hep C for > 6 months): Date of diagnosis:_____________ (***documents submitted should contain evidence of at least 6 months of viremia***)

□ Hepatocellular Carcinoma

□ 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

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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

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 □ Other: ________________________________
		□ Relapsed □ Partial Responder □ Non-Responder □ Toxicities □ Other: ________________________________

Laboratory Results

Baseline HCV RNA level (must be within 90 days of treatment start): _________________Date:________/________/________

Baseline AST: ________________________ Baseline ALT: ________________________ Date:________/________/________

Baseline hemoglobin: ___________________Baseline hematocrit:_____________________ Date:________/________/________

Baseline platelet:________________________________ Date:________/________/________

Medical History

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

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

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: ____