

HEPATITIS C THERAPY PRIOR AUTHORIZATION FORM

Incomplete forms will be returned

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
Does the patient have any history of medication non-adherence? No Yes; If yes, please explain below the details of non- adherence and how will it be addressed:

Diagnosis

Acute Hep C Chronic Hep C 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

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

