FLORIDA MEDICAID PRIOR AUTHORIZATION

HEPATITIS C AGENTS

Note: Form must be completed in full.
An incomplete form may be returned.

Recipient's Medicaid ID# | | | | | | | | | |

Date of Birth (MM/DD/YYYY) | | / | | / | | | |

Recipient's Full Name

Prescriber's Full Name

Prescriber License # (ME, OS, ARNP, PA)

Prescriber Phone Number | | | - | | | - | | | |

Prescriber Fax Number | | | - | | | - | | | |

What is/are the requested medication(s)?

☐ Sovaldi _______________ weeks
☐ Olysio _______________ weeks
☐ Harvoni _______________ weeks
☐ Technivie _______________ weeks
☐ Daklinza _______________ weeks
☐ Ribavirin* _______________ weeks
☐ Peginterferon alfa** _______________ weeks
☐ Zepatier _______________ weeks
☐ Other _______________ weeks

*Ribavirin: Provide drug, strength, and directions: ____

**Peginterferon alfa: Provide drug, strength and directions: ____

(If prescribing non-preferred alternatives, please provide documentation of a medical reason why the patient is unable to take the preferred medication)

PLEASE NOTE: VIEKIRA IS THE PREFERRED AGENT FOR GENOTYPE 1. IF THE DIAGNOSIS IS ON FILE, THE RECEIPIENT IS 18 YEARS OR OLDER AND IS TREATMENT NAÏVE, THE CLAIM WILL PAY FOR 12 WEEKS OF THERAPY WITHOUT A PRIOR AUTHORIZATION

Physician must submit all supporting documentation including lab results.

1. Does the recipient have chronic hepatitis C? ☐ Yes ☐ No
2. Is prescriber a hepatologist, gastroenterologist, infectious disease specialist, or transplant physician? ☐ Yes ☐ No
3. If no, is the prescribing physician in consultation with a specialist indicated above? ☐ Yes ☐ No
4. What is the recipient's HCV genotype? *(attach genotype test results)* ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
   - If genotype 1a, NS3 Q80K polymorphism? *(simeprevir requests only)* ☐ Yes ☐ No
   - If genotype 1a, please list any NS5A polymorphisms: (must submit documentation)

     ☐ M28 ☐ Q30 ☐ L31 ☐ Y93
5. Has the recipient been previously treated with HCV therapy? ☐ Yes ☐ No

   If yes, please specify date, regimen and duration: ____

   If yes, please document response to therapy: ☐ Null responder ☐ Partial responder ☐ Relapser

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6. Does the recipient have chronic HCV with cirrhosis? *(supporting documentation required)* ☐ Yes ☐ No

   If cirrhosis, what type? ☐ Compensated ☐ Decompensated

7. Child Pugh Score: ☐ A ☐ B ☐ C

8. Does the recipient have hepatocellular carcinoma? ☐ Yes ☐ No

9. Is the recipient HIV co-infected? ☐ Yes ☐ No
   (Must have documented diagnosis and must submit most recent CD4 count – within last 6 months)

10. Liver transplant? *(If yes, please specify date and submit supporting documentation)*

    ☐ Awaiting liver transplant (date): ___________________ ☐ No ☐ Post-transplant

11. Indicate HCV RNA level *(must submit lab results within the past three months for baseline).*

Treatment week	Log10	Date Measured
Pre-treatment baseline		

12. Has the recipient committed to the documented planned course of treatment, inclusive of anticipated blood tests and physician visits, during and after treatment? ☐ Yes ☐ No

13. For ribavirin therapy: If the patient is a female of childbearing potential, has a negative pregnancy test within 30 days of initiating therapy been submitted? *(Must submit results of test)* ☐ Yes ☐ No

14. Has recipient abstained from illicit drugs and/or alcohol consumption for a minimum of 1 month? *(Must submit results of test)* ☐ Yes ☐ No

    OR

15. Is the recipient receiving substance or alcohol abuse counseling services? *(Must submit supporting documentation)* ☐ Yes ☐ No

By signing below, the prescriber attests that all statements provided are accurate.

Prescriber Signature: _____________________________________ Date: _______________________________________

Fax Information to:

PERFORMRx℠

Pharmacy Provider Services
Fax: 855-825-2717
Phone: 1-800-617-5727