MARYLAND DEPARTMENT OF HEALTH
Medicaid Pharmacy Program

HEPATITIS C THERAPY PRIOR AUTHORIZATION FORM

Incomplete forms will be returned
1-800-492-5231-Option 3
Fax form to 410-333-5398

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:
_____

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. ****

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 (up to and including 90 days prior to treatment): _____ Date:_____/_____/_____

For all regimens please attach AST, ALT, total bilirubin and albumin.

If a regimen is prescribed containing Sovaldi, Harvoni® or Epclusa ®, please attach serum creatinine AND/OR eGFR.

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: _____/_____/_____

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 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.

_____

Prescriber's signature Prescriber's Name Date

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

Practice Specialty: _____

Address: _____

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