MedStar Family Choice

# Hepatitis C Therapy Prior Authorization Form

**Fax completed form to MFC-MD 1-888-243-1790 or 410-933-2274**

**A request must be accompanied by MEDICAL RECORDS that support the medication. MFC-Maryland will approve, deny, or request supporting medical records within 24 HOURS of receipt of the request. If MFC does not receive the necessary medical records to make a determination, we may allow up to 14 calendar days to submit required clinical records. Return by fax to MedStar Family Choice-Maryland at: 410-933-2274**

Patient Name:_____ Date of Birth:_____

Patient phone :_____ Patient address: _____

_____

**MEDICATION REQUESTED: _____**
**Number of weeks requested: _____**

☐ Check this box if patient was hepatitis C negative but is receiving/has received a **hepatitis C positive organ** (requests will be processed as URGENT).

**PATIENT HISTORY**

- Approximate date patient was diagnosed with Hep C: _____
- If less than 6 months ago, please state how your clinical judgement leads you to believe that this is CHRONIC hepatitis C (hepatitis C viremia ≥ 6 months):

  _____

  _____
- Cirrhosis: ☐ None ☐ Compensated/Child-Pugh A ☐ Decompensated/Child-Pugh B/C
- If cirrhotic (F4), please complete below:
  INR_____(must be <90 days old)
  Bilirubin_____(must be <90 days old)
  Albumin_____(must be <90 days old)
  H/o or current ascites:_____(yes or no)
  H/o or current encephalopathy:_____(yes or no)
- Previous treatment for hepatitis C (check all that apply):
  - ☐ None- patient is treatment naïve.
  - ☐ Pt was treated with IFN or IFN/Riba in_____(year)
  - ☐ Pt was treated with a DAA (direct acting antiviral, ex: Harvoni, Epclusa, Mavyret, etc.) in _____(year)
  - ☐ Pt was compliant with treatment and completed the full course but was a non-responder or partial responder.
  - ☐ Pt stopped therapy prematurely due to adverse effects.
  - ☐ Pt was cured of hepatitis C but reacquired it (please submit genotype prior to treatment and after treatment).
  - ☐ Other additional info you wish to convey:

    _____

**PLEASE SUBMIT THE FOLLOWING:**

For patients WITHOUT cirrhosis

- ☐ Hepatitis C viral load < 6 months old
- ☐ Genotype
- ☐ Fibrosis measurement < 1 year old (please note that NASH & ASH FibroSures are not accepted)
- ☐ Office note < 6 months old

For patients WITH cirrhosis

- ☐ INR, bilirubin, albumin < 90 days old
- ☐ Hepatitis c viral load < 90 days old
- ☐ Genotype
- ☐ Fibrosis measurement < 1 year old (please note that NASH & ASH FibroSures are not accepted)
- ☐ Office note < 90 days old

Additional labs required for the following patients:

- ☐ If prescribing Ribavirin- CBC
- ☐ If patient is HIV positive- HIV viral load < 6 months old showing viral suppression (<200 copies/mL)
- ☐ If patient is hepatitis B positive- HBV viral load < 6 months old

## By signing below, I, the prescriber of hepatitis C therapy, attest that:

- ☐ A treatment plan has been developed and discussed with the patient.
- ☐ I believe the patient can successfully adhere to and complete the full course of treatment.
- ☐ I will enroll the patient in other patient assistant drug programs to complete therapy should he/she no longer be eligible for Medicaid.

**Prescriber signature**:_____ Prescriber name: _____

Prescriber address: _____

Prescriber phone number:_____ Prescriber fax number: _____

Office Contact Name:_____ Office Contact Phone: _____