MedStar Family Choice

DISTRICT OF COLUMBIA

**Return by fax to 202-243-6258**

# HEPATITIS C THERAPY PRIOR AUTHORIZATION FORM

Patient Name: _______________________________________________

Patient DOB: _____________________

Patient Phone #: (_____) – ___________- ______________

Medication Prescribed: _________________________________ for ________ weeks
(Medication Name)

**Please check Yes or No box below:**

| Yes | No | Requirement |
|---|---|---|
| | | A treatment plan was developed and discussed with patient. |
| | | The patient will be able to comply/be adherent with full course of therapy. |
| | | The prescriber agrees to complete viral load testing 12 weeks after therapy has ended (to assess SVR). |
| | | If the patient's Medicaid eligibility changes during therapy and the patient is no longer eligible for Medicaid prescription drug assistance, the physician is prepared to enroll the patient in other patient-assistance drug program to complete therapy. |

**Please submit the following medical records including**:

a. Most recent office visit note(s) which must have the following details:
    i. List of all previous hepatitis C treatments; if none, the note must say "treatment naïve."
    ii. Child-Pugh score (if cirrhotic).
    iii. Social history with detail provided on use of ETOH and/or illicit substances.
b. Laboratory studies including:
    i. A recent (less than 6 months old) baseline viral load.
    ii. Genotype.
    iii. Fibrosis scoring (FibroSure, FibroTest, FibroScan, liver biopsy).
    iv. (if applicable) HIV viral load and/or hepatitis B viral load.

**By signing below, I certify that the information provided is accurate and that all the relevant medical records listed above are included in this submission.**

Prescriber's Name: ______________________________________

Telephone#: (_____) – ___________- ______________ Fax#: (______) - ___________ - ______________

Prescriber Address: ________________________________________________________________

Prescriber Signature:____________________________________________ Date:___________________________