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's NPI

Prescriber's Phone Number - -

Prescriber's Fax Number - -

Preferred Agents: Mavyret™ and Vosevi® (retreatment recipients)

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

What is the requested medication? *(include strength, directions, quantity and duration of therapy)*

_____

Physician must submit all supporting documentation including lab results.

1. Does the recipient have chronic hepatitis C? ☐ Yes ☐ No
   If yes, indicate the stage of fibrosis? _____
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
5. Has the recipient been previously treated with HCV therapy? ☐ Yes ☐ No
   If *YES*, please specify date, treatment regimen and duration: _____
   If *YES*, please document response to therapy: ☐ Null responder ☐ Partial responder ☐ Relapser
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

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8. Has the patient recently been tested for Hepatitis B Virus infection? *(Current lab work must be included.)* ☐ Yes ☐ No

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

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

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

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

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

Treatment week	Log10	Date Measured
Pre-treatment baseline		

13. 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

14. 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? ☐ Yes ☐ No

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

OR

16. 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's Signature: _____ **Date:** _____

REQUIRED FOR REVIEW: Copies of medical records (e.g., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs). **The Providers must retain copies of all documentation for five years.**

Mail or Fax Information to:
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