## FLORIDA MEDICAID PRIOR AUTHORIZATION



## **HEPATITIS C AGENTS**



Note: Form must be completed in full.

An incomplete form may be returned.

Re	cipient's Medicaid ID#	Date of E	Date of Birth (MM/DD/YYYY)												
			] / [		1										
Re	cipient's Full Name	<u> </u>													
Pre	escriber's Full Name		1	l									L		
	SCHOOL STUINGING														
	N										<u> </u>				
Pre	escriber's NPI														
Pre	escriber's Phone Number					Presc	riber's	Fax N	Numbei						
								-		-					
	referred A center Menuret IV cefeeburg	ir/volnotoov	ir (a	on orio	Enc	luco®	0) 004	4 \/oc	savi® (	rotrootr		rooi	nionto\		
FI	referred Agents: Mavyret™, sofosbuvi	ii/veipatasv	ii (g	enenc	⊏pc	iusa	), and	ı vos	evi (	retreati	Hent	reci	pierits)		
	prescribing non-preferred alternatives, pleas eferred medication.)	se provide do	cume	ntation	of m	edical	reaso	n(s) и	vhy the	patient i	s una	ble to	o take a		
•	,														
Wł	hat is the requested medication? (Include	strength, di	irecti	ons, q	uanti	ty, an	d dura	tion (	of ther	ару.)					
Ph	nysician must submit all supporting docur	mentation in	cludi	ng lab	resu	lts.									
1.	Does the recipient have chronic hepatitis C? (S	ubmit supporti	ng doo	cumenta	ation.)						☐ Yes				
	If YES, indicate the stage of fibrosis:	• •	-		,										
2.	What is the recipient's HCV genotype? (attach g	genotype test i	results	;)		1a [	] 1b	_ 2		3 🗌 4	. [	<u></u> 5	□ 6		
3.	Has the recipient been previously treated with F	HCV therapy?								□ Y	'es		☐ No		
	If YES, please specify date, treatment regimen,	and duration:					,								
	If YES, please document response to therapy:			☐ Nu	ıll resp	onder	P	artial r	espond	ler 🗌 F	Relaps	ser			
4.	Does the recipient have chronic HCV with cirrho	osis? (Support	(Supporting documentation required.)									Yes			
	If cirrhosis, what type?	. ,,	-			sated	·	ecom	pensate				☐ No		
5.	Child-Pugh Score: (Submit supporting documer	ntation.)								A	· [	∃в	□с		



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Rec	<u>ipient's l</u>	<u>Full N</u>	lame																							
6.	6. Has the patient recently been tested for Hepatitis B Virus infection? (Current lab work must be included.)											Yes				No										
7.	7. Does the recipient have hepatocellular carcinoma?												Yes				No									
8.	8. Is the recipient HIV co-infected? (Must have documented diagnosis and must submit most recent CD4 count – within last 6 months.)												Yes				No									
9.	9. Liver transplant? (If YES, please specify date and submit supporting documentation.)																									
	☐ Awaiting liver transplant (date): ☐ No ☐ Post-transplant																									
10. Indicate HCV RNA level: (Must submit lab results within the past six months for baseline.)																										
	Treatment week							Log10					Date Measured													
	Pre-tre	eatme	nt bas	seline																						
<ul><li>11. Has the recipient committed to the documented planned course of treatment, inclusive of anticipated blood tests and physician visits, during and after treatment?</li><li>12. For ribavirin therapy: If the patient is a female of childbearing potential, has a negative</li></ul>										☐ Yes					No No											
pregnancy test within 30 days of initiating therapy been submitted?																										
13.	Is the red	cipien	t rece	iving s	ubsta	nce o	r alcol	hol ab	use co	ounseli	ng se	rvice	s?									Yes	;			No
	(Must su	bmit s	suppo	erting d	ocum	nentati	on.)																			
By signing below, the prescriber attests that all statements provided are accurate.																										
Prescriber's Signature: Date:																										
RE(	REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes) and the most recent copies of related labs. The provider must retain copies of all documentation for five years.																									

**Call or Fax Information to:** Florida Community Care Prior Authorization

Phone number for non-specialty Prior Authorization: 877-433-7643 Phone number for specialty Prior Authorization: 866-814-5506 Fax number for non-specialty Prior Authorization: 866-255-7569 Fax number for non-specialty Prior Authorization: 866-249-6155

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