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)																					
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Red	ip	ient's	Full	Nar	me]		<u> </u>		J						Į.	Į	_]							
Pre	sc	riber'	's Ful	II Na	ame						I			l .		1					II				I				<u> </u>	
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Pre	sc	riber'	's NP	l I																										
Pre	sc	riber'	's Ph	one	Nui	mbe	r]								Pre	scri	ber's	Fax	Num	ber						
			_	. [_														_				_				
Wh	at	rred r	ie rei	que	ste															nd	dura	tion	of t	hera	py.)					
Does the recipient have chronic hepatitis C? (Submi If YES, indicate the stage of fibrosis:							-	-	_	ocum	entat	tion.)	ı] Ye	s			No						
2.	W	/hat is	s the i	recip	oient	ťs H	CV g	jeno	type?	' (atta	ach g	geno	type	test r	esul	ts)			1a		1b	□ 2	2	☐ 3] 4] 5		6
3.	Н	as the	e reci	pien	t be	en p	revio	usly	treat	ed w	ith H	ICV t	hera	py?] Ye	s			No
	If YES, please specify date, treatment regimen, and d											duration:								_										
	lf	YES,	pleas	se d	ocui	men	t res	oons	e to t	hera	ру:] Nul	l res	pond	er	☐ Pa	artial	resp	onde	r [Re	laps	er		
4.	Does the recipient have chronic HCV with cirrhosis?										sis?	' (Supporting documentation required.)									Yes				No					
	lf	cirrho	osis, v	vhat	typ	e?] Cor	nper	sate	d	□ D	econ	npens	sated						
5.	С	hild-P	ugh (Scor	re: (\$	Subi	nit sı	uppo	rting	docı	ımen	ntatio	n.)] A		В		С

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Rec	ipient's Full Name											
6.	Has the patient recently been tested for	Yes	☐ No									
7.	Does the recipient have hepatocellula		Yes	□ No								
8.	Is the recipient HIV co-infected? (Musi CD4 count – within last 6 months.)	☐ Yes	☐ No									
9.	Liver transplant? (If YES, please spec											
	☐ Awaiting liver transplant (date)											
10.	Indicate HCV RNA level: (Must submit	٦										
	Treatment week	Log10	Date Meas	ured								
	Pre-treatment baseline											
	Has the recipient committed to the doo of anticipated blood tests and physicia	☐ Yes	☐ No									
12.	For ribavirin therapy: If the patient is a pregnancy test within 30 days of initial	☐ Yes	☐ No									
13.	Is the recipient receiving substance or	Yes	☐ No									
	(Must submit supporting documentation											
Ву	By signing below, the prescriber attests that all statements provided are accurate.											
Pres	scriber's Signature:											
REC	QUIRED FOR REVIEW: All copies of ies of related labs. The provider must	medical records (e.g., diagno st retain copies of all docume	stic evaluations and rentation for five years.	ecent chart no	otes) and the mo	st recent						

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 Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (via return fax) immediately and arrange for the return or destruction of these documents. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited.

Page 2 of 2