Send completed form to:
Peach State Health Plan Pharmacy Department
Fax: 1-866-374-1579

Hepatitis C

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579**. If you have questions regarding the prior authorization, eligibility, drug copay or medication delivery; please contact Peach State Health Plan at **1-800-514-0083 option # 2.**

Patient Name: ______________________ **Date**: ______________________
Patient's ID: ______________________ **Patient's Date of Birth:** ______________________
Physician's Name: ______________________
Specialty: ______________________ **NPI#:** ______________________
Physician Office Telephone: ______________ **Physician Office Fax:** ______________
Physician Office Address: ____

1. Which drug(s) are being prescribed?
   Drug: ______________ Dose: ______________ Frequency: ______________
   Drug: ______________ Dose: ______________ Frequency: ______________

2. What is the diagnosis?
   ❑ Acute Hepatitis C ❑ Chronic Hepatitis D ❑ Other ____________
   ❑ Chronic Hepatitis C ❑ Essential thrombocythemia
   ❑ Chronic Hepatitis B ❑ Hepatitis C after liver transplantation

3. Is Hepatitis C therapy being prescribed by one of the following specialist?
   ❑ Gastroenterologist ❑ Physician highly experienced in treating Hepatitis C
   ❑ Infectious disease specialist ❑ None of the above

4. Check which, *if any*, of the following apply to the patient. If none apply, mark "None of the above":
   ❑ Less than 3 years of age ❑ IV drug and/or alcohol abuse within 6 months prior to therapy
   ❑ Decompensated cirrhosis ❑ None of the above (**Fax supporting documentation**)

5. Is the patient being retreated due to prior non-response or relapse with HCV therapy?
   ❑ Yes ❑ No **If no, skip to # 8*

6. Is this the first time the patient has ever been retreated? ❑ Yes ❑ No

7. Has the patient had a prior therapy with pegylated interferon (Peg-IFN) monotherapy? ❑ Yes ❑ No

8. Is Hepatitis diagnosis confirmed by a positive HCV RNA? ❑ Yes ❑ No

9. Document BASELINE viral load. ____________________IU/ml

10. What is the Hepatitis C Virus (HCV) genotype? ______________ (**Fax copy of results**)

11. Is the patient co-infected with HIV? ❑ Yes ❑ No

12. Document CD4 Count. ________________________cells/mm^3

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Patient Name: ________________________________ **Patients Date of Birth:** _________________________
Patients ID : ________________________________

13. Has combination therapy with Pegylated interferon and ribavirin been prescribed? ❑ Yes ❑ No

14. Check which, *if any*, of the following contraindications to ribavirin apply to the patient. If none apply, mark "None of the above":
❑ Female who is pregnant **or** using less than 2 forms of birth control if of child bearing age
❑ Male whose partner is pregnant **or** using less than 2 forms of birth control if of child bearing age
❑ Sickle cell anemia
❑ Thalasemia Major
❑ Renal insufficiency
❑ Ischemic cardiovascular disease
❑ None of the above

15. What is the patient's weight? _______________ (**in kg**)

16. What is the daily ribavirin dose?
❑ 800mg/day ❑ 1000mg/day ❑ 1200mg/day ❑ Other ________________

For Genotypes 1, 4, 5, and 6: If ribavirin dose is not 1000-1200 mg per day, what is the reason?
____

For Genotypes 2 and 3: If ribavirin dose is not 800 mg per day, what is the reason?
____

17. Is Hepatitis C confirmed by positive anti-HCV? ❑ Yes ❑ No

18. Has the patient had a liver biopsy showing evidence of one of the follow results? (**Fax results**)
❑ Stage 1 (or higher) fibrosis ❑ Moderate to severe degrees of inflammation and necrosis
❑ Neither of the above ❑ Liver biopsy was not performed

19. Is the patient currently receiving treatment for hepatitis C? ❑ Yes ❑ No **If no, no further questions*

Only answer below questions if patient is currently receiving therapy.

20. What date did patient start treatment? __________________________ (**mm/dd/yyyy**)

21. Is the patient currently receiving Peg-IFN monotherapy? ❑ Yes ❑ No

22. If patient is currently on a retreatment regimen, what is the current retreatment regimen?
❑ Combination Peg-IFN and ribavirin ❑ Other __________________________
❑ Infergen ❑ N/A, pt is on **initial** treatment regimen

23. Was there a 2 log decrease in HCV RNA (viral load)? ❑ Yes ❑ No ❑ Viral load is undetectable (**Fax copy of results**)

24. If patient did not have greater than or equal to 2 log decrease, was there an interruption in therapy?
❑ Yes ❑ No

25. If there was an interruption in therapy, has the underlying cause for the interruption been resolved?
❑ Yes ❑ No

****Fax all labs and progress notes with this request.**
We can NOT make a decision without a copy of the documentation. - Thank You **

Information given on this form is accurate as of this date:

X____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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