



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 License # (ME, OS, ARNP, PA)
Prescriber Phone Number
Prescriber Fax Number

What is/are the requested medication(s)?

Sovaldi _____ weeks
Olysio _____ weeks
Harvoni _____ weeks
Technivie _____ weeks
Daklinza _____ weeks
Ribavirin* _____ weeks
Peginterferon alfa** _____ weeks
Zepatier _____ weeks
Other _____ weeks

*Ribavirin: Provide drug, strength, and directions:

**Peginterferon alfa: Provide drug, strength and directions:

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

PLEASE NOTE: VIEKIRA IS THE PREFERRED AGENT FOR GENOTYPE 1. IF THE DIAGNOSIS IS ON FILE, THE RECEIPT IS 18 YEARS OR OLDER AND IS TREATMENT NAIVE, THE CLAIM WILL PAY FOR 12 WEEKS OF THERAPY WITHOUT A PRIOR AUTHORIZATION

Physician must submit all supporting documentation including lab results.

- 1. Does the recipient have chronic hepatitis C?
2. Is prescriber a hepatologist, gastroenterologist, infectious disease specialist, or transplant physician?
3. If no, is the prescribing physician in consultation with a specialist indicated above?
4. What is the recipient's HCV genotype?
5. Has the recipient been previously treated with HCV therapy?



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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
8. Does the recipient have hepatocellular carcinoma? Yes No
9. Is the recipient HIV co-infected?
(*Must have documented diagnosis and must submit most recent CD4 count – within last 6 months*) Yes No
10. Liver transplant? (*If yes, please specify date and submit supporting documentation*)
 Awaiting liver transplant (date): _____ No Post-transplant
11. Indicate HCV RNA level (*must submit lab results within the past three months for baseline*).

Treatment week	Log10	Date Measured
Pre-treatment baseline		

12. 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
13. 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? (*Must submit results of test*) Yes No
14. Has recipient abstained from illicit drugs and/or alcohol consumption for a minimum of 1 month? (*Must submit results of test*) Yes No
- OR**
15. 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 Signature: _____ Date: _____

Fax Information to:

PERFORMSMRX

Pharmacy Provider Services
Fax: 855-825-2717
Phone: 1-800-617-5727