



Hepatitis C Treatment Prior Authorization Form

Phone: 1-855-202-1091
Fax: 1-866-930-0019

Patient Information

Patient Name: _____ Date: _____
CareSource ID: _____ Patient DOB: _____
Patient's Address: _____ City/State/Zip: _____
Patient's Phone Number: (____) _____

Medication Information

Medication & Strength: _____
Directions: _____
Quantity: _____ Duration of Therapy: _____
Refills: _____

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Refills: _____

Physician Signature*: _____ Date: _____

*By signing above the physician is providing a prescription that can be used to facilitate dispensing and/or coordination of delivery for the requested medication.

Clinical Information

Documentation from the medical record including test results, lab reports medication history must be submitted to support answers below. **The genotype report, fibrosis level report and negative urine toxicology screen(s) MUST be provided or the prior authorization cannot be processed.**

- Does the patient have a diagnosis of chronic hepatitis C? Yes No
- What genotype does the patient have? (submit lab results from the past 6 months with PA request)
1 2 3 4 5 6
- If a subtype was detected please note here (e.g. a,b): _____
- Is the medication prescribed by a specialist (i.e. gastroenterologist, hepatologist, or infectious disease)? Yes No
- Is the patient treatment naïve? (If yes skip to question 10)
 Yes No Unsure
- Is this a request to extend or continue therapy from another plan? Yes No
If yes, how long is the requested extension? _____
- Has the patient been previously treated with a sofosbuvir-based regimen (Sovaldi, Harvoni)? Yes No
If yes, which medication(s) and how long? _____
- Has the patient been previously treated with an oral protease inhibitor (Incivek, Victrelis, or Olysio)?
 Yes No If yes, which medication(s) and how long? _____

9. Has the patient been previously treated Peg interferon & ribavirin? Yes No
If yes, how long? _____
10. Was the patient compliant with previous treatment regimens? Yes No
If no, why was therapy stopped?
11. Does the patient have stage 3 or greater hepatic fibrosis level? (submit lab results with PA request)
 Yes No
12. Does the patient have cirrhosis? Yes No
13. Does the patient have Hepatocellular Carcinoma that meets Milan Criteria and is awaiting liver transplantation? Yes No
14. Has the patient had a liver transplant? Yes No
15. Does the patient have HIV-1 co-infection and compliant with antiretroviral therapy? Yes No
16. Is the patient a previous abuser of illicit drugs or alcohol?
 Yes No (If no skip to question 18)
17. Is the patient a previous abuser of alcohol and have 3 consecutive monthly negative urine toxicology screens (drug & alcohol) in the last 120 days? (submit lab results with PA request)
 Yes No N/A
18. Has the patient had a negative urine toxicology screen (drug& alcohol) within the last 60 days? (submit lab results with PA request) Yes No
19. Has the patient had a baseline HCV-RNA greater than 50 IU/ml within the last 6 months? Yes No

Prescribing Physician Information

Physician Name: _____ Specialty: _____
 DEA #: _____ NPI #: _____
 Address: _____ City/State/Zip: _____
 Phone Number: (_____) _____ Fax Number: (_____) _____
 Office Contact: _____

Dispensing Information

Requested Dispensing Specialty Pharmacy: _____
 Phone Number: _____ Fax Number: _____
 NPI or Tax ID: _____ Address: _____

Criteria are based on CareSource Medical Policy. Approved prior authorizations are contingent upon the eligibility of the member at the time of service and the claim timely fill limits. Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits.