AmeriHealth Caritas™
New Hampshire

Hepatitis C Medications

Prior Authorization Drug Approval Form

Date of medication request: (MM/DD/YYYY): ____ / ____ / _____

Patient information and medication requested	
Patient's name:	Medicaid number:
Date of birth:	Gender:
Drug name:	Strength:
Dosing directions:	Length of therapy:

Prescriber information		
Prescriber last name:		Prescriber first name:
Prescriber address:		Prescriber representative:
Specialty:	NPI number:	
Phone #:	Fax #:	

Clinical history
1. Is the prescriber a gastroenterologist, hepatologist, or infectious disease specialist, or has one of these specialists been consulted in this case? ☐ Yes ☐ No If no to question 1, has the prescriber completed continuing education related to Hepatitis C? ☐ Yes ☐ No
2. Does the patient have a diagnosis of Hepatitis C? ☐ Yes ☐ No
3. Document patient's genotype.
4. Does the patient have a diagnosis of HIV or cirrhosis? ☐ Yes ☐ No
5. Has the patient been tested for Hepatitis B (using HbsAg and anti-HBc)? ☐ Yes ☐ No
6. Is the patient being treated for substance or alcohol use disorder? ☐ Yes ☐ No
7. Has the patient tried/failed a protease inhibitor or Sovaldi in the past? ☐ Yes ☐ No
8. Will the patient be on concurrent proton pump inhibitor? ☐ Yes ☐ No
9. Will the patient be on concurrent therapy with Ribavirin and/or Peginterferon? ☐ Yes ☐ No

Request for Sovaldi only (complete the following section)

1. Is the patient intolerant to Interferon? ☐ Yes ☐ No If yes, reason for intolerance:
Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.

If you are requesting a non-preferred product, proceed below.

Non-preferred drug approval criteria

Chapter 188 of the Laws of 2004 requires that Medicaid only cover non-preferred drugs upon a finding of medical necessity by the prescribing physician. Chapter 188 requires that you base your determination of medical necessity on the following criteria.

☐ Allergic reaction Please describe reaction:
☐ Drug-to-drug reaction Please describe reaction:
☐ Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information:
☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. Please provide clinical information:

Non-preferred drug approval criteria (continued)
☐ Age specific indications. Please provide patient age and explain:
☐ Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a reference:
☐ Unacceptable clinical risk associated with therapeutic change. Please explain:

Signature of prescriber:_____ Date: _____
(prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.