BIOSCRIP PBM SERVICES/JAI MEDICAL SYSTEMS MANAGED CARE ORGANIZATION, INC.
Call Clinical Services Department at 1-800-555-8513 or Fax 1-800-583-6010. BioScrip will respond by fax or phone within 24 hours of receipt of this request

HEPATITIS C THERAPY PRIOR-AUTHORIZATION FORM

Incomplete form will be returned

Please attach copies of the patient medical history summary, lab and genetic test reports to BioScrip.
****Please review our clinical criteria before submitting this form****

Patient Information

Recipient:_____ MA#: _____

Date of Birth:_____/_____/_____ Body Weight:_____ kg

Phone #: ( ) _____ - _____

Patient location: □ Home □ Hospital □ Clinic

Diagnosis (Attach genotype test results)

□ Acute Hep C □ Chronic Hep C □ Genotype of pre-transplant liver: _____
□ Hepatocellular Carcinoma
□ Genotype of post-transplant liver: _____ other:_____

What is patient's HCV genotype (including subtype)?_____

Has a liver biopsy been performed? □Yes □ No Test date : _____/_____/_____

Provide a copy of biopsy results or other fibrosis test, specify Metavir grade:_____ stage:_____

Hepatitis C Patient Characteristics

This request is for: □ New Therapy □ Relapser □ Partial Responder □ Non-Responder

□ Compensated cirrhosis (treatment naïve or experienced) □ No cirrhosis □ Decompensated liver d/s

Drug Regimen with Strengths/Dosages/Length of Therapy and Treatment Plan

Sovaldi®:_____ Olysio™:_____

Pegylated interferon: _____ Ribavirin:_____

Other: _____

Anticipated total treatment duration: _____

(Adherence with prescribed therapy is a condition for payment for continuation therapy for up to the allowed timeframe for each HCV genotype. The recipient's Medicaid drug history will be reviewed prior to approval.)

Has drug therapy treatment plan been developed and discussed with patient □ Yes □ No
Any issues with drug adherence? □ Yes Explain:_____ □ No
Adherence assessment:_____

Laboratory Results

Has a test been performed for the Q80K polymorphism? □ Yes □ No Test date: _____/_____/_____

Baseline HCV RNA level (within 60 day pre-treatment): _____ log10_____ Date:_____/_____/_____
HCV RNA Level at Treatment week 4 : _____ log10_____ Date measured:_____/_____/_____
at Treatment week 12 :_____ log10_____ Date measured: _____/_____/_____
at Treatment week 24 :_____ log10_____ Date measured: _____/_____/_____

Date of HCV RNA rebound (≥ 1 log10 increase from the nadir HCV RNA) any time while on treatment: _____/_____/_____

Liver enzyme levels: Baseline ALT/AST:_____ Date measured:_____/_____/_____

Baseline platelet:_____ Date measured:_____/_____/_____

Baseline hemoglobin/hematocrit:_____ Date measured:_____/_____/_____

Medical History

Does patient have HIV/HCV co-infection? □Yes □ No

Has patient had a solid organ transplant? □ Yes □ No Specify transplant date:_____/_____/_____

Does the patient have a history of any of the following:
□ anemia □ autoimmune hepatitis or other autoimmune conditions □ pregnant □ renal d/s □ thrombocytopenia
□ severe concurrent medical d/s (i.e. AIDS, cancer, significant CAD) □ hemoglobinopathies (i.e. sickle cell, thalassemia)
□ currently on didanosine □ unstable CVD

Does patient have history of depression or mood disorder? □ Yes □ No
If yes, is patient stable on current medication? □Yes □ No

Does patient have history of Drug/Alcohol Abuse? □Yes □ No If yes, is patient abstinent for last 6 months? □Yes □ No
If no, is patient currently in drug rehabilitation program? □ Yes □No

Prior Drug Utilization

List concomitant drugs that might interact with any of the prescribed Hep C drugs:_____
_____

List all previous hepatitis C therapies including adverse effects associated with prior therapy and reason for drug failure. If the patient is contraindicated or ineligible to receive a portion of a therapy (interferon), please provide a reason:_____
_____
_____

If patient's Medicaid eligibility change during therapy and patient is no longer eligible for Medicaid prescription drug assistance, is the physician prepared to enroll the patient in other patient assistant drug programs to complete therapy?

□ YES □ NO

I certify that the information provided is accurate. Supporting documentation is available for audits.

_____ Prescriber's Name: _____ Date: _____/____ /____
(Prescriber's signature)

Practice Specialty: _____

Telephone# (_____) – _____- _____ Fax# (_____) - _____ - _____

Address: _____