



# New Hampshire Medicaid Fee-for-Service Program Prior Authorization

## Drug Approval Form

Hepatitis C Medications

DATE OF MEDICATION REQUEST:      /      /

### SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH:

GENDER:  Male  Female

Drug Name

Strength

Dosing Directions

Length of Therapy

### SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER:

FAX NUMBER:

### SECTION III: CLINICAL HISTORY

- Is the prescriber a gastroenterologist, hepatologist, infectious disease or has one of these specialists been consulted in this case?  Yes  No  
If not, has the prescriber completed continuing education related to Hepatitis C?  Yes  No
- Does the patient have a diagnosis of Hepatitis C?  Yes  No
- Document patient's genotype, starting HCV RNA assay result and date taken.
- Does patient have a diagnosis of HIV or cirrhosis?  Yes  No
- Is the patient being treated for substance or alcohol use disorder?  Yes  No  
If yes, treatment confirmation: \_\_\_\_\_
- Has the patient tried/failed a protease inhibitor or Sovaldi in the past?  Yes  No  
If approved, additional HCV RNA assay lab work may be required at week 4, 8, 12 and/or 24 dependent upon drug.
- Will the patient be on concurrent therapy with Ribavirin and/or Peginterferon?  Yes  No

### REQUEST FOR SOVALDI ONLY (COMPLETE THE FOLLOWING SECTION)

- 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 to Section IV. If not, then refer to Section II.

### SECTION IV: 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       Drug-to-Drug Interaction
- Previous episode of an unacceptable side effect or therapeutic failure.
- Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug.
- Age specific indications.
- Unique clinical indication supported by FDA approval or peer reviewed literature.
- Unacceptable clinical risk associated with therapeutic change.

Please describe reaction: \_\_\_\_\_

Please describe reaction: \_\_\_\_\_

Please provide clinical information: \_\_\_\_\_

Please provide patient age and explain: \_\_\_\_\_

Please explain and provide a reference: \_\_\_\_\_

Please explain: \_\_\_\_\_

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.

PRESCRIBER'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_